DOCUMENT RESUME

ED 419 312 EC 306 396

AUTHOR	Watson, Kenneth
TITLE	Substitute Care Providers: Helping Abused and Neglected Children. The User Manual Series.
INSTITUTION	Westover Consultants, Inc., Washington, DC.; Circle, Inc., McLean, VA.
SPONS AGENCY	National Center on Child Abuse and Neglect (DHHS/OHDS), Washington, DC.
PUB DATE	1994-00-00
NOTE	81p.
CONTRACT	S-105-89-1730
AVAILABLE FROM	Clearinghouse on Child Abuse and Neglect Information, P.O. Box 1182, Washington, DC 20013.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Adoption; Behavior Problems; *Child Abuse; *Child Neglect; *Child Welfare; Childhood Needs; Children; Emotional Problems; Evaluation Methods; *Foster Care; Foster Family; Helping Relationship; Social Services; Systems Approach; Teamwork
IDENTIFIERS	*Substitute Care

ABSTRACT

This manual for child welfare staff and foster/adoptive parents is intended to provide guidelines for serving abused and neglected children who are in family foster care and adoption. The first section is on substitute care and permanency planning and offers an historical perspective on substitute care and definitions of family foster care and adoption. Next, the needs of abused and neglected children are addressed, including basic needs of all children, the special needs of children in substitute care, the special needs of abused/neglected children, and the individual needs of children. A section on systems, networks, and teams examines families as systems, the service network, the child welfare agency, and the substitute care team. Discussed in the section on meeting the needs of abused and neglected children are the assessment process, providing a safe environment, coping with regressive behavior, helping children with feelings of loss and issues of identity, and helping children who have been sexually abused. Next, support for foster parents is addressed in terms of foster home retention, training, and associations. Additional sections consider review and monitoring, a blueprint for family foster care in the 1990s, and issues in adoption for the 1990s. A glossary of terms is provided. An appendix lists special training programs for foster and adoptive parents. (Contains 46 reference notes.) (DB)

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ED 419 312

National Center on Child Abuse and Neglect

Substitute Care Providers: Helping Abused and Neglected Children

The User Manual Series

306396

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

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Substitute Care Providers: Helping Abused and Neglected Children

Kenneth Watson

1994

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

This manual, and other manuals in the series, are available from:

The Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, D.C. 20013

This manual was developed and produced by Circle Solutions, Inc., McLean, VA., under subcontract No. S 105-89-1730 with Westover Consultants, Inc.

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PREFACE

The Child Abuse Prevention and Treatment Act was signed into law in 1974. Since that time, the Federal Government has served as a catalyst to mobilize society's social service, mental health, medical, educational, legal, and law enforcement resources to address the challenges in the prevention and treatment of child abuse and neglect. In 1977, in one of its early efforts to achieve this goal, the National Center on Child Abuse and Neglect (NCCAN) developed 21 manuals (the *User Manual Series*) to provide guidance to professionals involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families. Some manuals described professional roles and responsibilities in the prevention, identification, and treatment of child maltreatment. Other manuals in the series addressed special topics, such as adolescent abuse and neglect.

Our understanding of the complex problems of child abuse and neglect has increased dramatically since the user manuals were first developed. This increased knowledge has improved our ability to intervene effectively in the lives of troubled families. Likewise, we have a better grasp of what we can do to prevent child abuse and neglect from occurring. Further, our knowledge of the unique roles key professionals can play in child protection has been more clearly defined, and a great deal has been learned about how to enhance coordination and collaboration of community agencies and professionals. Finally, we are facing today new and more serious problems in families who maltreat their children. For example, there is a significant percentage of families known to Child Protective Services (CPS) who are experiencing substance abuse problems; the first reference to drug-exposed infants appeared in the literature in 1985.

Because our knowledge base has increased significantly and the state of the art of practice has improved considerably, NCCAN has updated the *User Manual Series* by revising many of the existing manuals and creating new manuals that address current innovations, concerns, and issues in the prevention and treatment of child maltreatment.

This manual, *Substitute Care Providers: Helping Abused and Neglected Children*, is primarily designed for child welfare staff and provides the foundation for serving abused and neglected children who are in family foster care and adoption. As a companion to updated manuals for each profession, this manual is also intended for use by professionals involved in child protection: child protective services staff as well as law enforcement, education, mental health, legal, health care, and early childhood professionals. The manual provides information of value to foster and adoptive parents. Another manual in this series, *Preventing Child Abuse and Neglect: A Guide for Staff in Residential Institutions*, focuses on substitute care in residential settings.

ACKNOWLEDGMENTS

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SUBSTITUTE CARE AND PERMANENCY PLANNING

INTRODUCTION

The *Washington Post* in an editorial in September 1992, recounts the story of Robert, who entered substitute care when he was 14 months old because his mother had neglected him. He was returned to his mother when he was 22 months old, was back in care with a different foster family 3 years later, and subsequently was moved to yet a different foster home. At this point his mother signed an adoption relinquishment. The agency misplaced the relinquishment, inexplicably set family reunification as a new goal, and moved Robert to his fourth foster home. A year later he was in a group home, and the planning goal now read long-term foster care. At age 10 Robert was asked by a child psychiatrist to draw a picture of a person or play with puppets that looked like people. He refused. He said that you can't trust people, they die right in front of you.

Robert's situation poignantly underscores the problems children have when they do not get consistent care. Permanency planning is an attempt to provide stability and continuity in the lives of children who come into substitute care. It means planning for children so that they are reared in families that have the commitment and the capacity to meet their developmental needs until adulthood and that offer the opportunity for lifelong relationships and emotional support. Most children are reared in the permanence of their birth families. If, however, families are unable to meet their children's needs and provide permanence, the first priority of the child welfare system is to provide services that may help those families to meet the needs of their children. It may be necessary for children to be cared for temporarily away from their families. Then the goal of the child welfare system will be to strengthen the families as quickly as possible so they can meet their children's needs and be reunited. If children cannot have their needs met and cannot be protected from harm within their families, even with community support and services, the child welfare system is responsible for locating another family that can do that job.

The concept of permanency planning for children emerged in the early 1970's when professionals and the general public realized that many children were "lost" in the foster care system. Children had come into care because their families could not protect them or meet their needs. Agencies focused on helping these children adapt to foster care rather than directing efforts toward strengthening the birth families so they could care for their children.

The temporary nature of foster care offered little security in a child's life and little continuity in his/her caretaking. Once involved in the system, it was not unusual for a child to be moved from foster home to foster home. There was no clear way for a child to leave foster care except to run away or to grow up. A foster home that was relatively stable and able to meet a child's daily needs was more the exception than the rule.[1]

HISTORICAL PERSPECTIVE ON SUBSTITUTE CARE

Historically, our society has always been ambivalent about caring for dependent children. On the one hand, society has been moved by the innocence and helplessness of children in need. On the other hand, the public has resented such children because of anger toward the parents who bore them but did not rear them. The plight of these children, however touching, placed a burden on taxpayers who were now responsible for

their care. These children were viewed as helpless waifs who should be cared for at a minimum of expense and trouble to the rest of society. Thus, two parallel approaches to serving these children developed—family foster care and adoption.

The Development of Family Foster Care

The concept of foster care emerged as an outgrowth from poorhouses and orphanages—institutions that were designed to care for homeless children at the lowest possible cost to society. Two factors brought about the shift to family foster care. First, was the improved medical services that increased life expectancy and reduced the number of orphans. Second was the realization that many children reared in congregate care institutions were not well prepared to live in families as adults. When a child needed care outside the family, usually while the parents were struggling to find a way to bring him/her back home, family foster care came to be viewed as a more appropriate option than institutional care in meeting the child's needs.

Today, relatively few children enter foster care for reasons of dependency. Rather, social problems, such as family violence and drug addiction, are directly related to the increased number of foster children. Although the number of children in substitute care declined between 1980 and 1985, most likely in response to the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), that trend seems to have reversed. According to recent estimates, approximately 400,000 children are currently in foster care; by 1995 that number will exceed 500,000.[2] Moreover, data accumulated over the past several years also indicate that an increasingly disproportionate number of children in care are of racial/ethnic minorities.[3]

The Development of Adoption

Although foster care grew out of an attempt to rescue dependent children in orphanages, adoption service developed as a response to the desire of adults to have children. Historically, adoption has been linked to a family's need to secure an heir for a title, a name, or property, and, more recently, to meet the parenting needs of childless couples. Many adoption agencies came into existence to "solve" the infertility problems of adults affluent enough to support the agencies.

Adoption has been generally viewed as a solution for infertility as well as a way to save a child from a poor environment. To further justify the separation of infants from their birth parents, a third function of adoption was identified—to provide a solution for birth parents who were unable or unwilling to care for their child.

The Development of Permanency Planning

With the publication in 1959 of *Children in Need of Parents*, the professional community was made dramatically aware of the deficiencies in the substitute care system.[4] In 1960, Eugene Weinstein's study of children in foster care, *The Self-Image of the Foster Child*,[5] underscored the importance of promoting continuing ties between children in care and their birth families to make the placements more successful. By the end of the 1960's, there was increasing professional concern about how poorly the child welfare system was planning and caring for children in care. Questions were raised about the lack of good decision making that brought children into care, or encouraged them to stay there once they entered the system.

It was not until the mid-1970's that the concept of "permanency planning" gained recognition—largely a result of the "Oregon Project." This federally funded program demonstrated that many children in substitute care could either be returned successfully to their birth families or placed in adoption, pro-

vided there was the commitment and the concerted effort to bring about these results.

The combined results of research studies and professional experience tended to indicate the following:

- Many public and private child welfare agencies, acting *in loco parentis*, were doing a poor job of rearing children separated from their families.
- Children were drifting in and out of a child welfare system that had no clear plan for their future.
- Although birth families had been offered limited services to prevent the removal of their children, even fewer services were available while their children were in care to help these families overcome the problems that had led to their children's placement.
- If given the opportunity, many foster families were willing to adopt their foster children, especially if financial assistance was available to cover the extra expenses involved in the adoption and rearing processes.
- Other families were willing to adopt foster children who were not able to return to their birth families or be adopted by their foster parents.
- A critical factor in any child's development was continuity of care.

Advocates for child welfare reform had worked within the political process to change the system drastically. In 1978 the Children's Defense Fund published a study, *Children Without Homes*,[7] which mobilized public concern about the lack of planning for children in foster care. The result was the first piece of Federal legislation to deal with the issues of foster care and adoption. Public Law 96-272, The Adoption Assistance and Child Welfare Act of 1980, was passed in June of that year. Three of the law's most significant provisions are as follows:

- The Federal Government offered financial incentives to the States to encourage them to make real efforts to reunite children with their birth families, or, if that was not possible, to move the children to adoptive homes.
- Federal funds were also allocated to help with the adoption of children with special needs. These funds included adoption subsidies that is, direct financial assistance to families interested in adopt ing these children but lacking the necessary financial resources.
- Individual case plans and case reviews for children in foster care were mandated for States seeking Federal funds to assist in paying for the cost of such care.

As soon as Congress passed the Act, States quickly developed plans to obtain the Federal funds. As a result, many children in substitute care were provided with permanent alternatives. Some of the children returned to their birth parents or were placed in the homes of members of their extended birth family. Still other children were adopted by the foster families with whom they had been living. Between 1980 and 1985, the number of children in foster care declined by 9 percent.[8] The increased focus on case planning and case review activities mandated by the new Federal law also began to reduce the length of time children newly entering the system stayed in care.

Since 1985, there has been a steady and alarming increase in the number of children living outside the home. From 1985 to 1988, the number rose by almost 23 percent. If this trend continues, it is estimated that by 1995, there will be more than 553,600 children in foster care placements,[9] a 73-percent increase since 1980.

Moreover, children are coming into care at a younger age;[10] an increasing number are of color;[11] and they are staying in foster care longer.[12]

In 1990, the Select Committee on Children, Youth, and Families of the U.S. House of Representatives reported: "Since 1980, escalating rates of child poverty, growing numbers of births to unmarried teens, skyrocketing numbers of homeless families, growing substance abuse, a ninety percent rise in reports of abuse and neglect and now the deadly threat of AIDS—all interrelated problems—have placed increasing stresses on families and new demands on the system, jeopardizing its ability to serve appropriately children in need. Over a decade ago we were not even considering the impact of such problems on the child welfare system."[13]

The Development of Family Preservation Services

Although many of the causes of the current crisis lie beyond the child welfare system, managing the care of children whose families are not able to fulfill their parenting responsibilities does fall within the system. Paradoxically, for many children the preservation of their birth families includes temporary substitute care or adoption. An alternate approach is to provide intensive, short-term, in-home services to families whose children are at imminent risk of removal. Even though most family preservation programs are relatively new, initial studies indicate that they are a successful and cost-effective way to keep children out of substitute care.[14]

For children in foster care, the task of the child welfare system is to preserve and strengthen their families of origins so that family reunification can occur. For children entering adoption, the task is to preserve their birth families as a significant part of their identity by including those families in a new kinship network. Although the adoptive family is legally responsible for nurturing and meeting the developmental needs of the child, the adopted child also always "belongs" to the family that gave him/her life. The perception of foster care and adoption as family preservation tools means that the professional must learn to define adoption and family foster care differently.

NEW DEFINITIONS OF FAMILY FOSTER CARE AND ADOPTION

Foster Care

Family foster care is a means of temporarily meeting the developmental needs of the child by providing him/her with substitute extended family care for a period of time when neither the birth parents nor the biological extended family can meet the child's needs. It is important to note the use of the term *substitute extended family*. By viewing the foster family as extended family, a new model of care was developed that altered the roles of all parties involved.[15] In this model, the critical factor is the involvement of foster parents, who recognize the significance of the birth family to the child in care and who function as members of a team that is committed to reuniting the child's with his/her family whenever possible.

Kinship Care

Kinship care is a special form of family foster care in which the foster parents are members of the child's biological extended family. The reliance on a kinship network to care for children has long been a part of some cultures, and it is not unusual for relatives to assume the care for children when necessary. Child welfare agencies, however, have only recently begun to focus on kinship care. Currently in some States, more than half of all foster children are in the care of relatives. These relatives receive payment for the care, are required to meet certain requirements, and are offered services similar to other foster families. Although kinship care is being used extensively to relieve some of the pressure on the child welfare system caused by the shortage of foster homes, its complexities for the children involved are apparent, and its advantages are still being weighed.[16]

Adoption

Adoption is "... a means of meeting the developmental needs of a child by legally transferring ongoing parental responsibilities for that child from birth parents to adoptive parents, recognizing that in the process a new kinship network has been created that forever links those two families through the child who is shared by both."[17] This kinship network may also include significant other foster families, both formal and informal, that have been a part of the child's experience. Again, the term *kinship network* is significant. This definition recognizes that the creation of a new legal family by adoption, while transferring all legal rights and responsibilities to the new parents, neither destroys the existing families of the individuals involved nor undermines the continuing significance of those families. Rather, as in the creation of a new legal family through marriage, adoption expands the boundaries of the network to which all now belong. It also means that those involved have to negotiate relationships with the members of the family to which each belonged before the new family came into existence.

PRINCIPLES UNDERLYING SUBSTITUTE CARE

The approach to helping substitute care providers help abused and neglected children is based on the following principles:

- A child's basic needs are best met within safe, stable, nurturing families.
- Since a child is genetically, biologically, and historically a part of his/her birth family, a child who has been legally adopted will always belong to two families.
- Society's efforts should be directed first toward strengthening and preserving a birth family that can adequately meet the child's needs.
- A child may require substitute family care arranged by the child welfare system when neither the birth parents nor the extended birth families can meet the child's developmental needs.
- Foster care must be focused on meeting the child's immediate needs, preserving the integrity of the birth family for the child while he/she is in care, and returning the child to the parents whenever possible.
- Because they become a part of their foster child's extended family, foster families must negotiate relationships that support the birth parents and the goals of placement.
- Every family is different—moving to a new family is always a cultural shock for children.
- Ethnic and cultural similarities as well as ongoing relationships between families make the move easier for both the child and the families.
- Each child has the right to receive culturally competent care and services and to be prepared for self-sufficiency and independent living.
- Every child needs continuity of care. When the birth family cannot be helped enough to meet their child's ongoing developmental needs, the child should be legally adopted by a family that can provide a greater sense of belonging and permanence.

THE NEEDS OF ABUSED AND NEGLECTED CHILDREN

Being a successful parent to any child is a challenging task, and caring for children in substitute care can be truly complicated and demanding. Foster and adoptive parents assume responsibility for meeting the needs of the children they accept into their homes. To parent a child in foster care or in adoption is more challenging, especially when the child comes into care as a result of neglect or abuse. In order to meet the needs of these children, substitute parents must clearly understand the following:

- Abused and neglected children have the same basic needs as all children.
- As members of a group of children who are being cared for outside the home, abused and neglected children also bring a special group of needs.
- The needs of children in foster care are different from those of children in adoption.
- The effects of abuse and neglect usually create additional needs that may require special therapeutic interventions.
- Each child brings into care a unique set of individual needs that are a result of that child's genetic heritage, birth experiences, cultural identity, and past life experiences.

BASIC NEEDS OF ALL CHILDREN

Early childhood developmental theorists speculate that newborn infants, protected and nurtured *in utero*, enter the world with the expectation that this kind of care and protection will continue. Birth brings about a sudden change in environment. Because humans are born virtually helpless, they require a longer period of dependent caretaking than do the young of any other species. Very quickly, the infant begins to develop an awareness that the meeting of its needs depends on someone independent from him/herself. If its basic needs are not met by its caretakers, the infant soon becomes anxious about what will happen to him/her.

If a child is to survive and achieve satisfaction during adulthood, the following six basic needs must be met during infancy and childhood:

- security,
- nurturance,
- stimulation,
- continuity,
- reciprocity, and
- value orientation.

It is critical that the child has *all* of these needs met. Although it is difficult to arrange these needs hierarchically, the need for security is clearly the most important.

Abraham Maslow, one of the first of the humanistic psychologists, is perhaps best remembered for his theory of the hierarchy of human needs. He postulated that people could not focus on meeting their important individual growth needs until after their more basic universal needs were met. Maslow diagrammed his theory as a pyramid, with the most fundamental needs as a base supporting all the other needs.[18] On the lowermost level of the pyramid, he placed the physiological needs—air, water, food, shelter, sleep, and sex. At the second level, he put safety and security; at the third level, he included love and belongingness; and at the fourth level, he placed self-esteem as reflected by others. At the top of these four levels, he placed all of the individual growth needs.

Although having his/her nurturing needs met is essential to a child's survival, it is noteworthy that a child who is in care or at imminent risk of placement, and who is old enough to be conscious of his/her needs, is often more concerned about protection and security than about any of the basic physiological needs. Whether he/she will be fed, clothed, or sheltered is frequently of less immediate concern than whether or not the child feels safe. Positive caretaking during infancy and early childhood not only meets the child's physiological needs but also serves as the medium through which caretakers transmit the message that other needs will be met.

Infants need stimulation as well as protection and good nurturing. Those babies who are adequately nurtured but insufficiently stimulated may suffer from infant marasmus (i.e., infantile atrophy) and die. As the child grows and attempts to master appropriate developmental tasks, the need for stimulation continues rather than dissipates.

Consistent caretaking is another basic need. From birth to age 3, if a sound level of care and stimulation is missing, provided intermittently, or offered by a number of different caretakers, the child's capacity to trust may develop inadequately or be seriously damaged. This sense of trust forms the basis for learning to make attachments, and it is not unusual that children who suffer a loss of consistent caretaking usually demonstrate attachment disorders.

Reciprocity is yet another basic need. In this context, reciprocity means caretaker–child relationships that are characterized by mutual give and take and that are significant to both individuals. It is important, that as he/she grows up, the young child should realize that not only are adults important in meeting his/her needs, but the child is also important in meeting the needs of the adults. Because of the transitory nature of foster care, all too often children feel that they are interchangeable pieces in the lives of caretaking adults. Children who are adopted, often after the couple's prolonged attempts to achieve pregnancy, may view themselves as just one of any number of children who could have easily fulfilled the adult's need to be a parent.

Lastly, children need a value system to anchor and guide them. An important function of a family in any society is the acculturation of its children. Adults pass along values and beliefs by setting rules that reflect expectations of behavior, by determining what children come to view as important in terms of relationships to others and to their environment, and by reflecting their own values and modeling for children what they consider important. The value base established for children in their families is extremely difficult to alter or change in adulthood.

THE SPECIAL NEEDS OF CHILDREN IN SUBSTITUTE CARE

Foster and adoptive children are in care because they have lost, at least on a temporary basis, the family that gave them birth. A child comes into substitute care because of his/her parents' inability to meet some of these basic needs, or because of the wish of the birth parents to have someone else meet those needs. Because he/she is a foster or adopted child, a child in substitute care has special needs in addition to the basic needs of all children. Substitute parents must not only meet the normal developmental needs of the child placed in their care, but these other special needs as well.

These needs originate from the fact that every child in family foster care or adoption is a member of at least two families. The child belongs to its family of origin. No other family can ever take the place of the birth family. Through substitute care, however, the child has become a member of another family. This second family provides everyday care and meets the child's ongoing developmental needs for as long as the child lives with the new family. It is not unusual for a child in care to have lived in several families. In this case, the child may feel that he/she belongs to many families, including relatives, family friends, or other strangers who have provided care before the child was placed in his/her current home.

Whether coming into care for the first time or moving to yet another substitute family, the child arrives suffering the pain of a devastating loss, the loss of being taken away from his/her birth family. Placement away from the birth family means more than the physical loss of living with the family, it also means having to deal with the loss of relationships and the sense of loss of control over one's own life. There can be no greater blow to a child's self-esteem than to be abandoned or rejected by the people who brought him/her into the world. "Why did my parents give me away?" is a question that haunts all children in care.

Children coming into care suffer from the loss of their families and from damaged self-images. They are under a great deal of stress. Like anyone under stress, they try to find ways to behave that are easier for them and that relieve some of the stress. Generally, that means they regress and function in ways inappropriate for their age. They defend against their emotional pain, usually through denial or projection, or they consciously use learned behaviors to protect themselves, attempting to manipulate their environment without investing in new relationships.

The Special Needs of Foster Children

Normally, foster care is viewed as temporary, while a more permanent plan for the care of the child is being developed. Thus, all children in foster care suffer from a system-derived tension about where they are going to live and whether their needs are going to be met, *tomorrow*. No matter how good or loving the foster family, the child is aware that the stay is usually for a limited duration. Although the child has usually been told and retold that planning is underway to assure long-range security and well-being, most children in foster care are aware that a move is imminent. For most foster children, there is little opportunity for planned input or control over where and when that move will occur. Therefore, it is not unusual for the child to feel anxious and helpless; he/she may resort to behavior that, from his/her perspective, will have some influence on the decision to change placement. The child may somatize illness, run away, or act out in some other way.

Children in foster care are usually ambivalent about leaving their foster homes. Their individual histories, the current case plans, and the tie to their birth families all affect their feelings. Regardless of the family's past behavior or the quality of relationships with family members, it is the fantasy of every child in foster care to return to his/her birth family and grow up safely in his/her original home. Even children who clearly state a preference for continuing in foster care or moving into adoption harbor the fantasy that they will "go home." Because it is a fantasy, the foster child often imagines that everything will work out at home, despite the circumstances that first brought him/her into care. If the parents were abusive, the child may imagine that the parents have changed, will never abuse him/her again, and will somehow make up for the past.

Foster parents must meet their child's basic needs, yet be sensitive and responsive to the special anxieties that are inherent in foster care. A child in foster care is often anxious about being a foster child. He/she is, after all, trying to cope with a new situation and the loss of the birth family while struggling to learn how to fit into a family of strangers, and worrying about the plans that are being made for "permanent" care. Although the foster parents must try to help the children manage his/her behaviors, attempts to reduce the child's anxiety may not be in his/her best interest. It is natural for the foster child to be anxious—his/her status is unsettled, and unfortunately, foster parents cannot offer any promises or reassurances about the future.

The Special Needs of Adopted Children

An adopted child does not have to deal with the fantasy about returning home. The good news is that if he/she is adopted, the future seems secure, and the child will not have to move again. The bad news is that if the child is adopted, and the future secured with the adoptive family, the child will not be *able* to move again. That means that the hidden fantasy of returning to a reconstructed, now perfectly functioning birth family is no longer viable. The cost of the security and permanence of an adoptive family is the permanent loss of the birth family as possible nurturing parents. This is similar to what happens to children of divorced parents. Until the final decree, it is not unusual for the child to fantasize that the parents will reconcile and that the family will be reunited. Even after the decree is granted, the fantasy may persist. The child knows it is still possible for the parents to get back together and remarry. If either parent marries someone else, however, the child must acknowledge that it is highly unlikely that the birth family will ever be reconstructed. For an adopted child, the adoption conveys the same message—the birth family will never be reconstructed. Adoptive parents must help their adopted children deal with the death of the dream that they will ever go home again.

Increasingly, open adoptions are making it possible for children to have ongoing access to information and, in some instances, contact with their birth parents. Open adoptions can help resolve many of the conflicts that adopted children have about their status and the reasons for their adoption

THE SPECIAL NEEDS OF ABUSED AND NEGLECTED CHILDREN

Today, most children entering substitute care have been abused or neglected. The majority of these children have suffered deprivation or trauma in having even their basic needs met. It is especially important that child welfare professionals and substitute care providers understand the following:

- Abused and neglected children have *not* been kept safe; thus their capacity to trust and form meaningful relationships has been jeopardized.
- In almost all instances, abused and neglected children have *not* had their basic physical needs adequately met.
- Abused and neglected children may have been ignored and understimulated, or they may have been stimulated inappropriately through sexual abuse.
- Many abused and neglected children have experienced multiple, inadequate caretakers prior to, or perhaps while in, the formal child welfare system.
- Abused and neglected children have not been valued in their own right—they have been ignored, used for adult gratification, or treated as pawns in dysfunctional adult relationships.
- Abused and neglected children have often been exposed to values that society does not accept or hold in high esteem and that will not help them cope successfully in adulthood.

Most children with histories of abuse and neglect enter foster care at regressed developmental levels. Infants who are born addicted or with medical problems may come into care with physical and neurological problems and developmental lags. Older abused and neglected children enter care because their environment has failed to meet their needs. Because critical basic needs were not met, the children have been unable to master age-appropriate developmental tasks. These children may have had to expend considerable emotional energy surviving hostile or withholding environments, leaving little time to invest in routine developmental growth.

In addition to the trauma of the events that brought them into care, all foster children are subjected to the pain of separation from and the possible permanent loss of their birth families. This is more difficult for children who have been abused or neglected as well as for their foster and adoptive parents. Although society sees the separation of a child from abusing or seriously neglectful parents as an act of protection that is clearly in the best interests of the child involved, the child may perceive the placement as just one more traumatic event in his/her sad life. As one child arriving at her first foster home said through her tears, "Don't leave me here. I'd rather be beaten by my mamma than by strangers."

As the abused or neglected child adapts and begins to feel more secure and comfortable in his/her foster home, new issues arise. The child is caught between the longing to return to the birth parents and the fear of what could happen if this actually occurred. The ache of separation from the families of birth is especially intense because of the relative comfort and security of the foster homes in which the child now lives.

An abused or neglected child placed in adoption has a more difficult time integrating the two families than do other adopted children. All children in adoption struggle to bring into their lives with their adoptive families the parts of themselves that belong to their pasts. For a child who has been abused or neglected, that includes the history and trauma of those experiences. It is also difficult for adoptive families to allow the child to "bring in" the abusive parents by responding to the child's questions or by sharing the child's earlier experiences. Adoptive families want to deny the impact of those experiences to protect the child from painful memories and to protect themselves from facing the reality of those experiences.

One of the paradoxes of adoption, however, is that the more the adoptive family allows the child to bring in memories of experiences with the birth family, the more the adopted child will belong to the adoptive family. By accepting the whole child, including an abusive or neglectful past, the adoptive family reaffirms acceptance and love of the child.

It is not unusual for an abused and neglected child in substitute care to have problems in school. The placement circumstances and the energy needed to cope with feelings of loss, a poor self-image, and the trauma that brought the child into care leave limited energy for learning. In addition, many children in care have learning disabilities, often the result of deprivations that occurred prenatally or in earlier childhood. Many abused and neglected children also choose school as the arena in which to act out their feelings. Misbehaving at school puts the child in less jeopardy than misbehaving at home.

Sexually Abused Children

It is estimated that from 75 to 85 percent of the children currently in foster care have experienced some form of sexual abuse.[19] Although many children may enter care because of known sexual abuse, increasing numbers are disclosing sexual abuse after entering care for other reasons. Once secure in the foster or adoptive home, it is not unusual for a child to reveal his/her earlier victimization.

Both statutory definitions and public perception vary about what constitutes sexual abuse of children.[20] For the purposes of this manual, sexual abuse is defined as "any activity or interaction where the intent is to arouse and/or control the child sexually."[21] One researcher identifies the following three differential factors that can help to distinguish abusive from nonabusive acts and that can provide some guidelines for assessment and treatment:[22]

- a *power* differential that implies that one party exerts some control over the other and that the encounter is not mutually conceived and undertaken;
- a *knowledge* differential that stems from the fact that the offender is chronologically older, more developmentally advanced, or more intelligent than the victim; and

- a *gratification* differential that recognizes that the purpose of the encounter is the satisfaction of the offender and that any gratification of the victim is in the interests of, or incidental to, the offender's pleasure.

Although there are several categories of sexual abuse, incest and systemic family sexual abuse are the most common. Most of the sexually abused children coming into substitute care report having experienced either or both of these forms of abuse. Other types of sexual abuse include rape, ritualistic sexual abuse, and sexual exploitation for profit (e.g., prostitution, sex rings, and pornography).

In both incest and systemic family abuse, there is some relationship between the abuser and the victim, and the abuse can be viewed as fulfilling some dynamic function within the family system.

- **Incest**. This is the best known type of abuse. It usually involves an immediate family member or paramour as the abuser, generally lasts for a period of time within an established trust relationship, and often occurs with the knowledge and covert approval of other family members.

- **Systemic Family Sexual Abuse**. This is probably the most prevalent type of sexual abuse among children coming into foster care. It is usually only one symptom of family dysfunction that may also include alcohol and drug abuse and the physical neglect and abuse of the child. The family system casts the child in the role of victim; the abuse takes place within the family; and there may be multiple abusers. Usually, the parents participate in or encourage the abuse; at a minimum, they fail to offer the necessary supervision and protection and allow the abuse to continue. Sexual activity is often initiated in infancy, and the child may grow into adulthood without recognizing the behavior as abusive. Such abuse is often not disclosed by the foster or adopted child until after he/she is safely in care.

The Impact of Sexual Abuse on the Abused Child

Sexual abuse makes most people very uncomfortable. It upsets them to think that adults inflict physical and psychological pain on child to gratify their own pleasures, especially when the adults are trusted family members or friends.

Although the reactions of family and society surely have some impact on the long-term impact of sexual abuse, especially of very young children, research findings from 40 studies clearly indicate that sexual abuse causes real and profound problems for most abused children and their families.[23]

These problems can be classified as falling into one of the following four major areas:

- Sexual abuse can undermine the child's ability to trust adults.

- Sexual abuse can lead to an altered view of sexuality.

- Sexual abuse can cause reactive or protracted emotional states (such as depression, anxiety, or fear).

- Sexual abuse can generate behavioral problems reflecting the above (e.g., poor adult relationships, sexual dysfunction, substance abuse, or suicide).

In their review of the current literature, Minshew and Hooper add to the list of possible problems—the weakening of the child's will as a result of a sense of powerlessness, the negative connotations that may be incorporated into the developing self-image of the abused child, and role confusion as a result of unclear parental boundaries.[24]

The Impact of Sexual Abuse on Foster and Adoptive Parents

Sexual abuse brings to the surface strong feelings on the part of those who care about the well-being of children. Most prospective foster and adoptive parents are shocked that such terrible things can happen to a child and are enraged at the parents who participated in the abuse or allowed it to happen. Foster and adoptive parents must reconcile their own feelings before they can help the child victim. The foster and adoptive parents cannot, of course, condone the behavior of the abusive parents, and they must generate an environment in which the sexually abused child is not only safe from harm, but also feels secure enough to share and recover from the trauma of the abusive experience. Neither the foster and adoptive parents nor the abuse victim can ever forget that the parents who sexually abused the child (or allowed the abuse to take place) are still the birth parents of that child. A sexually abused child must come to terms with that reality. The child can only do so if the foster or adoptive parents are able to accept that part of their child's previous life experiences.

Because most sexual abusers are intrafamily perpetrators,[25] helping the child overcome the effects of the abuse within a family setting seems to be the best approach. Therefore, a child welfare agency has an especially important responsibility in recruiting and developing appropriate and caring foster and adoptive homes for children. That responsibility is threefold:

- To ensure that prospective substitute parents understand and confront the likelihood that most children coming into foster care and most special needs children available for adoption have suffered from sexual abuse.
- To assist prospective foster and adoptive parents in clarifying and understanding their own feelings about child sexual abuse and the impact of those feelings on their capacity to be effective parents to a sexually abused child.
- To provide the training and support that foster and adoptive parents need to deal with the implications and problems of rearing a sexually abused child.

Medically Fragile Children

A growing number of children are beginning life already the victims of parental neglect. Because their mothers have not obtained proper prenatal care, these infants are born suffering from the effects of their mothers' addictions, illnesses, youth, or poor general health. Included in this group are low-birth weight babies; alcohol or other drug-affected babies; and babies whose mothers may have transmitted infectious diseases to the babies *in utero* (e.g., mothers who have AIDS or who are HIV-positive).

These children, as well as children who suffer from genetic difficulties or birth injuries, are medically fragile. Whatever the nature of the medical problem, these children make great demands on their caretakers and on all of the members of the families in which they live. Many medically fragile children come into foster care, and some are available for adoption. Most of these children have special medical needs that complicate their care and place increased stress and responsibility on their caretakers. Many medically fragile children are developmentally delayed because of their physical condition, and all are suffering from the impact of the placement itself. Thus, the foster and adoptive families who will be caring for these children must be selected carefully. Social service agencies must also be prepared to provide the additional training and support that these families will require.

Prenatal Substance Abuse

There are a number of unanswered questions about the impact of a mother's use of drugs on a developing fetus. In some instances, such as in fetal alcohol syndrome, the problems the child will face have been clinically determined. The long-term impact of other drugs, such as crack cocaine or "ice," is not fully understood. The full extent of possible neurological damage cannot be assessed until the child reaches later developmental stages. This problem is further compounded because newer "designer drugs" are constantly appearing and because many mothers are polyaddicted.

Within broad limits, however, there are some behaviors of infants associated with prenatal substance abuse. For instance, infants prenatally exposed to drugs may alternate between periods of irritability and lethargy, may frantically suck their hands, become tremulous, or engage in prolonged or high-pitched crying.[26] They may suffer seizures, fever, sweating, diarrhea, or excessive regurgitation. If their mothers have abused stimulants, these infants tend to be easily overstimulated, and they may move from periods of sleep to loud crying within seconds. Whatever the specific symptoms, these children prenatally exposed to drugs will require patience and special nurturing skills; they often need close medical supervision and monitoring. Thus, these children require a special kind of foster or adoptive parent.

In addition to the usual qualities required for foster or adoptive parenting, individuals who accept medically fragile child must cope with the following:

- a greater number of unknowns (e.g., unpredictable behaviors resulting from the uncertainty of the prenatal drugs involved, lack of knowledge about the developmental impact of newer drugs, and uncertainty about whether an HIV-positive child will develop AIDS, etc.);
- a new focal point in their lives that will assuredly alter their lifestyle and limit their mobility;
- multiple appointments with medical and rehabilitative personnel;
- working with a complex interdisciplinary team;
- the use of medical techniques and equipment that are essential for the monitoring or caretaking of the infants (e.g., apnea monitors, cardiopulmonary resuscitation, suctioning, etc.);
- advocating for the services the child may need;
- stress on all family members because of the amount of caretaking that the fragile child demands; and
- the possibility of deterioration or death after heroic efforts to maintain the child's life.

THE INDIVIDUAL NEEDS OF CHILDREN

In addition to commonly shared needs, each foster or adopted child also brings into care his/her own unique earlier traumas and unmet needs, and foster or adoptive parents must meet the specific needs of each child for whom they care. Sound substitute care can provide the opportunity for the foster or adoptive child to overcome much of the impact of earlier painful experiences. The child can recover many earlier missed developmental opportunities and get back on his/her own developmental track. Although some children may require professional help, substitute caretakers are often in the best position to act as "primary therapists" and to provide the kind of therapeutic input that the child needs most. Child welfare staff have the task of helping identify the specific needs of each child, of assisting the parents learn to deal effectively with those needs, and of making additional professional services available when necessary.

SYSTEMS, NETWORKS, AND TEAMS

In their efforts to help children and their families, people interact with one another as members of systems, networks, and teams. Often these terms are used interchangeably, but it may be useful if the following distinctions are made.

SYSTEMS

A system is a group of similar items, ideas, or people that are interrelated so that they form a new entity that is greater than the sum of the component parts. This new entity has a "life of its own." Systems are identified by their boundaries. What lies within those boundaries is part of a particular system; what is outside the boundaries is the larger universe within which that system functions. The boundaries of a system are determined by its objectives and components and by the ways in which those components are related to each other. A component may be a part of more than one system simultaneously, and a system can be a part of yet a larger system.

For example, the human body is a system. Clearly, it is more than the sum of its component parts, has a life separate from those parts, and functions as it does because of the way those parts are related to each other. A human body as a system is a person, and this person also functions as a component of other larger systems, for instance, a family.

Systems function according to the following interrelated principles:

- Systems are governed by rules that define and limit the function of the component parts and the way those parts interact.
- Systems strive to achieve a balance (i.e., homeostasis) so they can operate smoothly.
- Though not inflexible, systems resist change because any change in any part of the system or in the system's structure upsets the system's homeostasis and demands change throughout the entire system.
- Systems tend to try to maintain their stability, cohesiveness, and integrity by making limited, ongoing, self-correcting adjustments in response to feedback from any component part.
- New components to a system are viewed as intrusive foreign entities that threaten the system's stability, and they tend to be rejected by the momentum of the homeostasis of the system.

Networks and teams can be viewed as systems. A more discrete definition of each enables the members to be more aware of the particular function that each serves in helping children in substitute care.

NETWORKS

In this context, networks can be defined as a number of individuals or organizations that are interconnected to accomplish a goal that each feels is worthwhile. Networks can be established formally with the members working together all the time (in this case, the network can be viewed more clearly as a system) or can be an *ad hoc* arrangement that functions as a network only to achieve a particular goal. Membership in such networks is informal, and members may come and go according to their commitment to the goal and their capacity to make a contribution.

TEAMS

A team can be defined as two or more people who have identified a common goal and have agreed to work together to achieve that goal. The success of the team is predicated on the concept that each member has individual strengths and talents and that people working together can achieve a common goal more easily and effectively than they could by working separately. The team concept is very popular among many professional disciplines. It can be utilized when several different groups work together closely on behalf of someone receiving service (e.g., social workers, lawyers, foster parents, therapists, school officials, and parents working on a team to achieve greater permanency for a child) or when individuals sharing the same discipline work together (e.g., several child welfare caseworkers make a team decision about plans for a child's adoption).

FAMILIES AS SYSTEMS

It is often helpful to perceive a family as a system of individuals. Usually, families do not recognize that they are systems and are unaware that, as in all systems, they are subject to the principles discussed above. Family systems are structured according to the roles that various members play to keep a particular family system functioning smoothly and by numerous tacit rules that govern that particular system operates. Often, professionals talk about a family as being "functional" or "dysfunctional." This is an attempt to describe whether a family system is effectively meeting the individual needs of its members as well as maintaining its own homeostasis. When a family system can maintain itself as well as meet the individual needs of the family members, it is considered to be functional. A dysfunctional family is one that may function successfully as a system, but fails to meet the developmental needs of individual members.

The Impact of Placement on Family Systems

In our society, children grow up as members of families. The placement of a child affects the system of the family that the child leaves as well as that of the family that the child enters. Placement also creates a new family system that incorporates both families. Any decision to subtract or add a child to a family always impacts that family system. Members of families usually do not perceive themselves as part of a system, and they are not consciously aware of family system dynamics that influence their actions. If child welfare caseworkers or others do not understand and consciously work within the conceptual context of family systems, these dynamics also can be overlooked in planning for and helping children in substitute care.

Often, it is useful to help the families involved gain greater awareness of their family system dynamics. Family-oriented professionals make use of several techniques, such as having family members write down the rules that govern their particular system, identifying the roles that each family member plays, engaging families in family sculpture, or charting the decision-making process within the family.

Whenever a member enters or leaves, family systems become temporarily unbalanced. When a child enters substitute care, the family system that the child leaves becomes askew. The family boundaries are changed, its function is probably modified, roles of the family members must be renegotiated, and the old rules no longer apply. The reason for the placement and the expectation that the placed child will or will not be returning also impacts the way that the family system reacts. The family must struggle to regain its equilibrium.

For instance, a family in which a child is being abused has established a balance that is predicated upon that abusive behavior. If the abused child is placed, the family system becomes unbalanced. The family's boundaries are changed by the child's absence, as is the relationship of the members of the system to each other. The function of the family is altered by the loss of the child. The roles that family members had played to help hold the system in balance before the placement are no longer valid, and each member of the family must find a new role. The abuse of the placed child fulfilled some function within the family. If that function is still

important to the family system, it must now be fulfilled in some other way—perhaps by shifting the rules by which the system is maintained or perhaps by assigning the role of the abused person to another family member.

A child enters a new family system with expectations based on his/her previous experiences. If a child is accustomed to being the abused person in the family, it is likely that the child will seek to fulfil this role in his/her new surroundings. The new family system, however, has a different set of dynamics; it already has a role for the child that is based on the way that family functions.

Foster Families and Family Systems

By being aware that systems tend to react to new elements as intrusive, a foster family can try to accommodate the newly arrived child into its existing system by redefining every family member's role in ways that will reestablish the family balance yet meet each family member's individual needs. If foster care fulfills its function, those new members that the foster family worked so hard to incorporate will be able to leave, and the family system will once again have to readjust its balance. These families must constantly work to maintain themselves as functional units as each foster child arrives or leaves.

Adoption and Family Systems

Because their boundaries are usually more fixed, family system changes may be more difficult for adoptive families than for foster families. Although the adopted family plans to incorporate the child on a permanent basis, its family system is more resistant to change. The role that is assigned the new child is often more clearly defined, while at the same time the tie between the adopted child and the family remains tentative.

An adoption of an older child may fail because the child coming into the family has no awareness of the role he/she is expected to play in that family or because the child repeats a role that had been assigned and practiced in another family. That role may already belong to another member of the adoptive family; this may be a role that is not syntonic with the new family; or it may be a role the child played in a previous placement in a dysfunctional family as a means of protection or control but which is inappropriate in a more functional family system.

A fairly common example of this dynamic is the preteen girl who joins an adoptive family after having suffered sexual abuse. Within the former family system, parental attention, pleasurable intimacy, and perhaps survival depended on her sexualized relationship with an adult male in the household. She will practice what she has learned and can be expected to sexualize her responses to her new father and perhaps act inappropriately. If the adoptive family consists of a childless couple who are experiencing sexual tensions, the child may be supported in an unhealthy role she knows all too well. A different scenario involves an adoptive family that wants the preteen to be the community "showpiece" and may focus efforts on correcting the child's "seductive" behavior. The family's actions may create unrealistic expectations leading to rejection of the child as not "fitting in." The integration of the child into the new family is easier when the adoptive family is aware of its own dynamics as a system and of the role that the child played in other families or placements.

An adopted infant has a very special status. That child usually represents the "prize" at the end of what may have been a long and arduous journey for an infertile couple. Some agencies have traditionally supported the fantasy expectation that the parents may have for such a child by labeling him/her the "chosen child." Even though that terminology is no longer encouraged, both the adoptive family and the child may sense the special role the child is to play.

THE SERVICE NETWORK

The placement into foster care or adoption plunges the child and the various families into a network of community services. Although all of the parts of this network may be committed to providing service, each unit has a different vantage point, and each part of the network tends to view its contribution as the most critical. Both the child and the families are best served, of course, when the various components of the network are clearly identified, the function of each component is understood and respected, all parties have communicated effectively, and the responsibility for coordinating the various parts of the network has been delineated.

The service network can be defined by the organizations or individuals who are a part of that network. For most children in substitute care, the network includes the following:

- the child and the family;
- the agency providing substitute care;
- the actual care providers (foster parents, adoptive parents, child care workers);
- courts;
- schools; and
- other community agencies meeting the specific needs of the child (e.g., hospitals, mental health specialists, rehabilitation specialists, and various support groups).

Birth Family

Children are the focus of child welfare services, and it is for them that substitute care plans are necessary. Every child comes to placement with a family already attached. The focal point of the network in support of a child is that family. A child comes into care because his/her family is not able to protect the child and meet his/her needs; however, the family still remains a critical element in the network of services.

The specific role that each family will play depends on the permanency goal for the child. That goal and the particular needs of the child shape the selection of the child care resource most suitable for the child, thus making a difference in how the family fits into the network. If a child is placed in a foster home, and the goal is eventual return to the birth parents, frequent and spontaneous visits by the parents can be critical. If the child is placed at a treatment institution, visits are arranged to suit the therapeutic plan and the policies of the institution. If the child is in adoption, contact with the birth family may be negotiated as part of the development of the extended kinship network.

Child Welfare Agency

Increasingly, infant adoptions are being arranged independent of agencies. However, most foster parents work with a child welfare agency, and most special needs child are adopted through agencies. The responsibilities of child placement agencies are usually defined by various statutes, legislative rules, and licensing requirements. The role of the agency is further shaped by other legal boundaries and by the policies of the agency itself. Generally, some authority for the care and planning of the child has been delegated to the particular child welfare agency that exercises control over what happens to the children in their program. To successfully care for a child, the agency structure must delegate most of the responsibility for the daily care of the child to direct care providers. The agency assumes the role of case manager, a role that is discussed later in this manual.

Direct Care Providers

The direct care providers are the substitute foster and adoptive parents (or child care staff in group homes or institutional programs). These individuals play the most significant role in anchoring the child while the network of available services are brought to bear. They function both as a part of the agency program and as entities apart from the agency program.

Court

Because its role is to protect the child and use its authority to enforce a plan that is deemed in the child's best interests, the court plays a crucial role for any child in substitute care. For most individuals, courts are formidable places. Appearing in court may be associated with being charged with or punished for wrongful behavior or with attempting to resolve some bitter dispute. The case manager, usually the child welfare caseworker, is responsible for presenting the child's needs to the court, interpreting the court's role, and mitigating the negative feelings that the court may engender in other team members. Recently, courts have tended to go beyond traditional judicial roles through involvement in administrative casework issues.

Schools

Schools play a vital role in the development of children. Not only are they charged with the cognitive development of children between the ages of 5 and 18, but schools also function as an extension of the family in meeting the broader nurturing and developmental needs for many children. Schools are also the primary source of peer contact and provide the first alternative arena for the child to explore values other than those learned at home.

Almost without exception, a child coming into care exhibits the impact of placement through performance in school. The child may also reflect the impact of his/her life history, including previous placements, neglect, abuse, and most likely, an irregular school experience in which the child has invested little. As a result of these experiences, the child's cognitive development may lag behind his/her chronological age. The child may be emotionally unable to commit to learning; he/she may suffer from diagnosed or undiagnosed learning disabilities; or the child may choose school to act out more general concerns. A young child may have so much of his/her emotional energy drained by dealing with the loss of the birth family that by the time he/she is old enough to start school; he/she is unable to perform well scholastically.

Thus, the cooperation and involvement of the school system is usually critical to the success of substitute care. In an Illinois survey of 395 randomly chosen families who had adopted special needs children, the adoptive families identified special education as the service they needed most.[27]

A child in either foster care or adoption is sometimes in educational jeopardy. School personnel may feel that the child in foster care does not really belong to that community and is an extra burden on school staff and the tax payers. As a result, some educational systems may be reluctant to provide or develop special services for foster children. An adoptive child, of course, legally "belongs" to the community, but educators may subscribe to the myth of the "adoption syndrome." This syndrome hypothesizes that all adopted children are likely to manifest a certain cluster of problems. The danger of such a perception within the school is that an adoptive child may be stigmatized, become the victim of self-fulfilling prophecies, or have individual needs that are unidentified or unmet.

Therefore, the child welfare agency responsible for the placement of the child, as well as the foster and adoptive parents, must maintain regular contact with the school. The purpose of this contact is to improve the communication and the understanding of both parties about the impact of substitute care on the child's school performance and behavior. The goal is to maintain the school as an ally in identifying and helping meet the needs of the child.

Community Resources

Additional resources in the service network for child in substitute care depend on the communities involved and the needs of the child. Many children bring into placement educational handicaps, emotional problems, developmental deficits or delays, or other concerns that can be addressed by community resources. If a child's specific needs are identified, resources to help meet those needs can then be included in the service network. For example, the child who has educational difficulties may require tutoring; the child who is exhibiting emotional distress may need counseling; a family overwhelmed by the caretaking demands of a severely disabled child may need to join a support group focused on that particular difficulty; and a family troubled by the complexities of managing the care of a special needs child may require respite care.

A needed resource may not always be available. It is then the responsibility of the parents and the agency to advocate for the development of such a resource. One example is that of respite care for substitute parents who are caring for special needs children. In the previously mentioned Illinois survey, 26 percent of the families indicated they had a need for respite care but only 6 percent had actually used this service.[28] The survey did not document the reasons for families not using services but in this particular case, respite care was not yet available in many parts of the State. Recently, respite care has become more readily available as foster parents have identified it as a critical need, and agencies have come to recognize how useful it can be in helping preserve foster care placements that may be in jeopardy.

Managing the Services Network

Most children in substitute care do not require a broad array of services, and the amount of any given service that a child needs varies. Often, families feel that the children get too much or too little access to services. The case manager is responsible for guiding the family and child through the network of service providers as well as matching the needs of a particular child or family with the appropriate services.

Thus, sound case management is more than merely coordinating resources. It also involves identifying the appropriate resources, knowing how to access those resources, and making those resources available in a way that empowers, not demeans, those needing service.

Substitute parents need community services to do their job, but they are also essential to the coordination of such services, determining the fit between their schedule and the services. Often, the substitute caregivers must exercise parental prerogative to ensure that the child gets the appropriate services.

At times, foster and adoptive parents may be somewhat reluctant to make full use of the network of services. Two characteristics demonstrated by successful foster or adoptive parents are their problem-solving skills and their sense of being able to adapt to the demands and accomplish the tasks that substitute parenting requires. Such individuals, however, may have difficulty in recognizing their own shortcomings and in calling upon others for assistance. Substitute parents may feel that any attempt to involve the community in helping them may portray them as inadequate as parents.

Although both adoptive and foster parents must "prove" their competency to be approved as substitute care providers, adoptive parents have tended to feel more vulnerable. Until recently, the relationship they had with the agency was terminated when the adoption was consummated. Many agencies discouraged adoptive parents from returning if they were experiencing difficulties. Rather, the agencies would recommend that the parents use some other community resource. Thus, the message was both that the adoptive family was now like any other family (which it can never be), and that the agency had no interest in assisting the adoptive family in dealing with its problems. However, the current emphasis on postlegal adoption services has fostered an allied role for agencies in helping adoptive families at every developmental stage of the child.

Many agencies have found that when new families are introduced to the concept of the resource network during their orientation, they are more comfortable in accessing resources, if necessary. Some agencies ask community resource personnel to discuss with groups of potential parents the typical developmental difficulties they may encounter with their children as well as provide information on available services. This approach has proved helpful for the parents; they not only learn about community resources, they also become acquainted with community service providers. Currently, many agencies also make use of experienced foster and adoptive parents during their orientation or preservice training. These families can provide first-hand information about the community network and the various services they may have used. Often, new parents team with experienced parents in what is called a "buddy system" to provide additional support and information.

THE SUBSTITUTE CARE TEAM

Most professionals recognize that the needs of the child in substitute care can best be met by an intra-agency team. The team consists of the child's parents, the foster or adoptive parents, agency personnel, and possibly, the child him/herself.

As with any successful team, a team working on behalf of meeting the needs of an abused or neglected child must include the following five critical components:

- a common, identified goal;
- an emotional connection among members;
- mutual respect;
- defined roles; and
- clear communication.

Establishing a Common Goal

If the team is to succeed, a common goal must be identified, clearly articulated, and accepted by all members. In athletics, usually the foremost team goal is to win games. Everyone on the team recognizes that goal, and each member must consider achieving that goal as the first priority. If any player has a different goal, not shared and accepted by the other players, the team's effectiveness is diminished. If one player's goal is to break the individual scoring record, and another player's is to retaliate against someone on the other team for some past offense, the team will likely fail to achieve its overall goal of winning the game.

To help abused and neglected children, the initial stage of a successful team effort is the statement and agreement on the goal or goals. This is not as easy, or as common, as it appears. The foster care system is based on outmoded premises. Traditionally, foster parents have been recruited by emphasizing three related, but fallacious, ideas:

- Good parenting is all that is necessary to be a good foster parent.
- A foster child's needs are essentially the same as those of other children.
- A sound environment can overcome any problems that the foster child may have.

Until quite recently, birth parents have had little input in the planning for their child in foster care. When the child came into care, it was often the case that the birth parents were treated as though they had no further

rights or responsibilities regarding the child. Agencies either worked hard to maintain the child in foster care (as if that were the primary goal) or tried to get the child out of foster care in order to provide placement for another child.

The result has been a fragmented approach to foster care. Some potential team members have become uneasy with other members. Too often, foster parents are focused on meeting the immediate nurturing needs of the child in their care. Agencies are struggling to work out case plans toward permanent placement for the child and provide the supplementary therapeutic services. Birth parents are striving to overcome a number of personal problems as well as deal with the foster care system, and the child is expending his/her energy to manage his/her anxiety about the future.

The goals for a particular birth family should be clearly articulated in the initial case plan; it may be appropriate for these goals to be discussed in collaboration with the foster parents. Regardless, the goals must always be shared with the foster parents, and the birth family must be told about this sharing process. The inclusion of the foster family in the goal setting (or when that is not possible, the sharing of the goals with the foster family) underscores the foster family's role as a team member. This approach also has implications for the recruitment and training of foster parents by forming the basis for open, ongoing communication among all team members.

Developing Emotional Connections

An agreed-upon cognitive goal has little meaning unless there is an emotional alliance among the team members. This concept has long been recognized in athletics. A successful coach will readily acknowledge that whether a team wins or loses a game depends more on each member's commitment and enthusiasm than on individual talents. Athletic teams work hard to develop this emotional tie. They use team names, uniforms, mascots, cheers and songs, and rituals. This dynamic is also present in the foster care team. However, because of the different perspectives of the principals involved, the child welfare agency must take responsibility for developing this emotional alliance.

Each person lives in a different cognitive world, and his/her viewpoint is a product of individual perceptions. It is often hard to understand those whose backgrounds differ from one's own. For people to work together on a team, they must "feel" related to the others involved. Such an alliance is not possible if the team members rely only on the cognitive agreement on goals. Commitment is an emotional experience. Although everyone lives in different cognitive worlds, they share the same emotional world. It is through making an emotional bridge that people can really come together.

In substitute care, the feeling of loss is common to all team members. Loss is a universal experience, and each person has a reservoir of feelings related to personal losses upon which he or she can draw. In addition, substitute care by definition provides a loss experience for those involved. The birth parents lose their child, the child loses the birth family, foster parents lose a child who has become a part of their family, adoptive parents have "lost" a child not born to them, and the caseworker loses a child and the families as they move out of agency care. By acknowledging and discussing these losses, and by tapping into the feelings that the loss represents to each of those involved, participants in substitute care can find a common emotional language and a way to feel related to one another.

Mutual Respect

To work effectively, the members must have mutual respect for the special contribution that each can make. Each team member must acknowledge and respect the others on the team for who they are and for what they can contribute. This may not always be easy. Parents who have abused their child or who behave in antisocial, irresponsible, or unpredictable ways are not always respected by those who are caring for their child or

by the social services agency. It is easy to lose sight of the common base of humanity that each person shares with those parents, the circumstances that bring about their behavior, the pain that behavior may have caused them, and what they may mean to their child. To generate respect is to work to understand those parents, to keep establishing the common ground that enables individuals to make connections with each other, and to recognize any positive experiences or values that the parents have given and have yet to give to their child.

Often, it is also difficult for birth parents to respect the other team members. Foster parents may see themselves as helping the birth parents by providing good care for their child. The birth parents may view the foster parents as rivals for the child's affection. Caseworkers may see themselves as "doing good" and "helping" the child and the families. For birth parents, the caseworker may represent an intrusive, hostile system that has possibly forced the placement of their child. It is also likely that foster parents may perceive agency staff quite differently than staff perceive themselves. It is the agency that licenses the foster parents and decides which child will be placed in foster care. When there are disagreements about planning, the agency falls back on policies or procedures to resolve the issues. Until quite recently, child welfare caseworkers have been somewhat unsure about how to categorize foster parents. They have been called "caregivers," "resources," "clients," "employees," "cotherapists," and "team members." Unfortunately, in many situations, foster parents have been treated with condescension as often as with respect.

Fulfilling Defined Roles

Mutual respect depends on not only recognizing the contribution that each member may have made in the past, but also on clearly defining the role that each is to currently play. How roles are fulfilled depends on the following:

- the range of the roles that are open for the participants to play,
- the capacities and motivation of the individuals involved, and
- how the roles are defined within the case plan and the acceptance by each team member of their assigned roles.

In foster care, there is a tremendous potential for role confusion. It is not unusual for birth parents and foster parents to compete to see who the child will view as parents; the agency and the foster parents may struggle over the issues of control and responsibility; birth parents and their child may disagree with the agency around matters of planning; and the child may exploit the shared parenting situation either consciously or unconsciously.

Substitute care involves shared parenting. It is important to remember that the child is initially rooted in the birth family; any substitute care plan is an attempt to extend family boundaries to meet the child's developmental needs. The fact that a child is being cared for by foster parents does not negate the birth parents' rights or responsibilities. Whenever possible, birth parents should be involved in making decisions about their child in all but routine family matters or in situations requiring immediate action. For instance, changes in a young child's hairstyle ought not be arbitrarily decided by the foster parents without input from the birth parents.

Clear Communication

Although a team cannot function successfully if it lacks any one of the five critical components mentioned earlier, probably the one component most crucial for ongoing success is communication. If communication is frequent, open, and clear most difficulties in other areas can be addressed and solutions achieved. If communication is unclear or nonexistent, almost certainly team members will drift apart, and the team approach will break down.

Effective team communication develops when rules are clearly delineated and team members consistently adhere to those rules. Good communication develops with practice. The following five rules lead to effective communication, regardless of the situation:

- Be direct.
- Be honest.
- Keep it simple.
- Be kind but avoid euphemisms.
- Listen actively.

MEETING THE NEEDS OF ABUSED AND NEGLECTED CHILDREN

This manual cannot teach the full range of skills and techniques that foster and adoptive parents must use to help them meet the needs of maltreated child living in their homes. However, this section will attempt to present several concepts to guide those who work with the child in substitute care and share some specific techniques that can be useful.

It was suggested earlier that abused and neglected children in substitute care demonstrate the following:

- the same developmental needs characteristics of all children;
- needs that are unique to their status as foster or adopted children;
- needs that relate directly to their past history of neglect; and
- individual needs relating to their own histories and the particular circumstances that brought them into care.

The assessment process is intended to sort out the various levels of need and to help focus therapeutic intervention where it is most needed and will be most effective for each child.

THE ASSESSMENT PROCESS

Assessment is the process of gathering and evaluating information and comparing that information to some sort of normative data. In assessing a child who is already in substitute care or who is entering care, professionals must be mindful of two norms. They must be knowledgeable about what constitutes normal behavior based on a sample of all children at various chronological ages, and they may recognize what is considered normal behavior for children of various ages who are also in substitute care.

The assessment of a child in substitute care is geared toward understanding how the child functions cognitively, socially, and emotionally. It is also important to understand the impact that placement has had, or will have. Whenever possible, information should be gathered directly from the child, the child's caretakers (both past and current), other professionals who have known the child, and from recorded information about the child.

Information should be gathered and organized according to the following nine categories:

- developmental functioning,
- attachment,
- loss,
- identity,
- coping mechanisms,

- situational needs and responses,
- understanding of status and expectations for the future,
- relationship to and meaning of birth family, and
- personal style and specific idiosyncratic needs or expectations.

Developmental Functioning

The level of a child's development is usually assessed in five areas. First is physical development. Child welfare staff must determine whether the child has developed within the normal range of physical growth and is in good health, or if there are delays in physical development or special medical concerns. Second is social development. The caseworker must assess how the child interacts with the environment, particularly with other people. Third concerns the child's emotional responses. Are they appropriate for a child of that age? Fourth is cognition. The caseworker must understand that the chronological age and physical development of the child is especially important because cognitive capacity is more difficult to measure for a preschool-aged child or for a child whose physical development may be slower than the norm. Fifth is the degree of congruence among the other four areas of development. Although all children develop somewhat unevenly, most children develop in the above areas at about the same rate. A child coming into care usually shows greater discrepancies among the various developmental areas or even significant lags in one or more of these areas.

Attachment

The capacity to make meaningful attachments is important throughout life. It is especially important to assess this capacity for a child in care because attachment capacity is something that can influence the success of care or that can be therapeutically strengthened as a result of care.

Attachment is a learned skill. If a child has his/her basic needs met from infancy to age 3, the child will also learn to trust and become affectually involved—first with the primary caretaker and then with others. Many children coming into substitute care have not experienced a stable, nurturing, consistent relationship with an adult during their first 3 years. As a result, these children come into care with various forms of attachment disorders.

During assessment, the caseworker must discern the child's capacity to make attachments or identify the nature of any attachment disorder. Attachment disorders fall into three categories. Those children who have been severely deprived of nurture and affection during their first years may be children who are *nonattached*. Simply put, because they have never experienced a meaningful attachment; further, these children do not know how to form such a relationship.

The second type of attachment disorder, more common to children in foster care or adoption is that of the *inadequate attachment*. These children have had their basic needs met at various points during their early years, but their primary attachment was interrupted by the necessity of having multiple or intermittent caretakers. A child demonstrating inadequate attachment might have had several placements between infancy and age 3, or the child may have had a primary caretaker who was a substance abuser who took good care of the child when not under the influence. An inadequately attached child responds well to substitute care that is consistent, allows for regressive behavior, and makes no immediate demands for affectual closeness with other family members. In time, the child can learn how to become affectually involved, though not always to the degree that might have occurred if he/she had an opportunity for consistent early care.

A third type of attachment disorder is demonstrated by a *traumatized* child. In this situation, a child had been experiencing sound caretaking and was developing a positive view of the world and of relationships when some traumatic event interfered. The young child might have been sexually abused by a trusted adult, or the child might have had to deal with the sudden loss of a primary caretaker because of death or placement in care. Although such attachment disorders are serious, they are the most easily treated. In the case of anticipated death or placement, the trauma can be mitigated by explanation, preparation, sensitivity, and postplacement contact. If the caretaker's loss is unexpected, or the trauma is due to sexual abuse, treatment based on the posttraumatic syndrome model can be effective. In assessing the impact on a child who suffers from an attachment disorder caused by trauma, it is important to consider the child's age when the trauma occurred, the nature of the trauma, and the capacity and the stability of the substitute home to which the child is moved.

A child who learns attachment when older never learns as well as if it was learned at a more age-appropriate stage of development; however, subsequent interventions can help mitigate these attachment disorders. Trust is a key element in the child's recovery. Trust can be learned, and it is the beginning of the healing process. A preschool-aged child can learn attachment if he/she is placed in an environment in which the child has an opportunity to form a significant primary attachment by regressing to an infantile level and having his/her needs met by a consistent caretaker over a prolonged period of time.

Between the ages of 5 and 11, a child can learn attachment if adult caretakers can create opportunities for the child to have earlier caretaking needs met symbolically. Caretakers must design ways to interact with the child just as a mother would interact with an infant or toddler while discouraging infantile behavior and without inappropriately stimulating the child. Examples include an adoptive mother who structured regular, intimate parental touching by washing and combing her daughter's hair, or a foster mother who put sunscreen on her 10-year-old son's back as a safeguard against exposure to the sun when he was swimming in an outdoors pool.

Adolescents can be helped to learn attachment by demonstrating appropriate behavioral skills, such as how to hold eye contact or how to hug. Young adults may learn attachment if they become involved in a relationship with someone who is a competent caretaker, or they may learn attachment techniques in the process of helping their own children learn how to attach.

Loss

The assessment of losses in the lives of children relates directly to their capacity to make attachments and is a critical factor in planning and implementing successful substitute care. The loss of family is a core issue in the placement of any child. The child's earlier experiences determine how he/she reacts to that loss and what interventions can be most helpful. In addition, any other losses the child might have sustained, the circumstances and timing of those losses, how the child managed those losses, and the extent to which those losses have been resolved are factors that should be assessed.

Losses are resolved successfully by experiencing a grieving process; that process takes time and support. Any new loss during the grieving period means the process must start anew, and a series of successive losses may stall the process completely. Because they want to ease a child's grief, adults respond by trying to block the child's grief or by speeding up the process. Adults involved with a child in substitute care need to understand the child's past experiences with loss, and they need to be comfortable with helping the child grieve. Techniques to assist foster parents deal with a grieving child will be described in a later section of this manual.

Identity

"Identity" is a sense of one's self and of one's boundaries and values. Identity includes knowing who we are

and how we fit into our surroundings. Because we spend all of our lives becoming who we are, our identities are never fully formed. There are, however, six critical components to one's identity that evolve throughout the normal development of children. Those components are as follows:

- **Origins**. The base of a person's identity is his/her origins. Who a person is and who he or she becomes is initially shaped by the individual's genetic heritage. One's gender, physical attributes, intellectual capacity, and a predisposition to certain illnesses are determined at conception and provide a foundation upon which a person bases a sense of self. Each person is also born with ancestors. Who they were and what they did are also a part of one's identity.

- **Reflections**. A child's image of him/herself is reflected from the child's caretakers and provides the next layer of his/her developing identity. This includes an awareness of how the child is viewed by his/her caretakers and other family members, the similarities between the child and other family members, and the value that is attached to the child through the pride that others take in the child's appearance or achievements.

- **Autonomy**. In addition to how the child feels that he/she is viewed by others, a young child also begins to develop an awareness of autonomy and a sense of the limits of his/her body. As the child begins to perceive him/herself as an individual, the child masters the use of personal pronouns (I, me, my, mine) and an image of his/her body. The child distinguishes him/herself as a separate entity, and as the child recognizes the differences in the appearance of body parts, including sexual parts, he/she takes another step in defining him/herself.

- **Belonging**. One of the first external boundaries that a young child learns is that of family member ship. One of the characteristics of a family system is the way in which boundaries are established and the permeability of those boundaries. A young child quickly learns that he/she belongs to a family and the identity of the other members of that family. Family membership also establishes the child's identity within the broader community. Before a child is known as Mary Smith, she is known as "the youngest Smith girl" or as "Bobby Smith's little sister."

- **Conscious Choices**. As a child matures, he/she observes people who are important to the child, and he/she begins to decide if he/she wants to grow up to be like those people. The child often consciously imitates others' behavior and then, perhaps unconsciously, incorporates certain characteristics into his/her own identity. The child can also decide to accentuate one aspect of his/her life experience or a particular role he/she has played in the family or in the community and make it the basis of his/her identity. For instance, if it serves his/her purposes, the child may present him/herself as a clown, victim, or foster child. That image can be internalized and serve as the organizing principle which shapes the way the child perceives the world and views him/herself.

- **Self-image**. At the center of the developing identity is a person's internal image of self. The value that one attaches to that self is of critical importance to one's sense of identity. Identity suggests that one has defined oneself and drawn boundaries around what one has defined. One does not define and draw boundaries around something that has no value.

The identity of a child in foster care or adoption is often shaped by the circumstances that initially brought him/her into care and by the experience of being in foster care. The child usually faces difficulties with every component of identity mentioned above:

- **Origins**. Information about the child's origins may be limited, lost, blurred, confused, or deliberately withheld or distorted.

- **Reflections.** From infancy or early childhood, the child might have had inadequate or multiple care takers and thus has no experience in seeing him/herself as a whole, valuable, and loved individual.

- **Autonomy**. Because of inadequate caretaking, the sense of autonomy for the child coming into care might not be fully developed. Even a child who has had positive early caretaking experiences suffers from an acute sense of helplessness as a result of the placement. A child coming into care usually regresses to a much more dependent level of functioning, and depending on subsequent experiences, the child may experience continued impairment in developing a sense of identity.

- **Belonging**. By definition, adoption or foster care makes it less clear to a child to whom he/she "belongs." Some foster parents, in an effort to deal with their own pain about the plight of the child in care, encourage their foster child to use the foster family name or to call them "Mom" and "Dad." Some foster and adoptive parents discourage the child from talking about his/her experiences and feel ings about the birth family. A child with special needs often experiences several placements (to relatives, foster parents, hospitals, residential institutions, or adoptive homes). These experiences add to the inherent confusion that a child in care has about belonging and to the difficulty the child may have in developing his/her own identity.

- **Conscious choices**. A child who has been exposed to numerous role models has a harder time sorting out what it is he/she *wants* to be or feels he/she *can* be. This is especially true if any exposure to a role model has been traumatic. An adopted or foster child may also cling to his/her role as a foster or adopted child and attempt to build a sense of identity around that core.

- **Self-image**. An adopted child has suffered enormous negative impacts on his/her self-esteem by being "given away" by the birth parents. *The success of the care can temper the impact of this blow; but it can never fully compensate for it.* Even a newborn adopted directly from the hospital and reared by a family who meets all of the child's developmental needs must deal with the impact of what may be perceived as rejection by the birth family. Although the circumstances of the situation may make foster or adoptive care the most logical and appropriate solution, even the best explanation does not eliminate the perception by the child that his/her parents did not want the child.

Coping Mechanisms

Children are remarkably resilient. Whatever their early experiences, most have developed ways to manage their lives. Children are not always aware of what mechanisms they use or just how they learned them. Some of these ways are unconscious defense mechanisms, which will probably never be identified. Other responses, however, are conscious techniques that a child has learned from his/her own experience or from observation. For some children, these behaviors (or coping mechanisms) have become habitual, although most children are not usually aware when they utilize them. Other children, however, very consciously and deliberately use these techniques.

It is useful for substitute parents to have some sense of the types of coping mechanisms a child is likely to employ so they can better understand the child and respond appropriately when the child exhibits such coping mechanisms. It is also important for child welfare staff to identify these behaviors and evaluate whether they are likely to work to the child's long-term advantage or whether efforts should be made to alter or replace the behaviors.

Testing

A child coming into substitute care needs to determine the "dimensions" of the setting. The child needs to learn such things as family boundaries and roles, the important rules of the household, the expectations that are being placed on him/her, and the tolerance for and the consequences of misbehavior. Children determine boundaries in several different ways. Some children immediately engage in testing behavior; that is, they quickly push to the limits to learn what those limits are. Other children need a period of acclimation before they do their testing; and still others learn what they need to know from observation alone and never engage in direct testing behavior.

Manipulation

Often, a child who has been moved frequently learns to cope through manipulation. The child may become a practiced liar, able to persuade foster parents, caseworkers, teachers, and strangers the truth of false statements. Another child may learn how to "play off" the other members in the family to his/her advantage. Yet another child may carefully observe the kinds of behavior and expressions of feelings that seem to work for others and mimic these behaviors in his/her relationships. Such a child may lack the capacity to feel as deeply as another person or be unable to express that feeling in a genuine way, but he/she will pretend to have the feeling if he/she thinks that it is expected or that it will be to his/her advantage.

Repetition

A third kind of coping behavior that is useful to assess is the repetition of patterns of behavior that are based on the child's past experiences. Sometimes the behavior appears bizarre or self-defeating unless professionals understand its roots and the reasons for its repetition. For instance, if a child has experienced trauma in the birth family or in a previous placement, the child may try to recreate the experience in an attempt to master residual feelings from the earlier experience. If the child has experienced rejection in the past because of his/her behavior, he/she may repeat the same behavior to see it if will elicit a similar response, or the child may engage in similar behavior but try to stop before suffering such dire consequences. This is an attempt to master the behavior or manage the trauma more than to test the new family. The child is trying to gain greater control over the circumstances of his/her life.

Situational Needs and Responses

One important, but often overlooked, area of assessment is a child's situational needs and responses. Professionals often view a child's behavior as distinct from the environment in which the child lives. What appear to be character traits can in fact be spontaneous responses. What may appear to be negative character traits can be a healthy reaction to an unhealthy situation. A change of environment can solve many problems. It is, therefore, extremely important for the caseworker to assess what needs and behavior are situational by becoming familiar with the child's total environment.

Understanding of Status and Expectations of Future

Another factor in assessing a child in substitute care, or a child for whom such care is being considered, is to observe the child's understanding of his/her situation and what substitute care entails. How a child perceives care and what that child views as its best and worst resolutions are significant factors in case planning. A child's understanding will be limited by age, by past experience, and by the degree of the child's involvement in the planning. That understanding will also be shaped by what the child perceives as actually happening. This can be best assessed through interpersonal interaction with the child. An older child can usually articulate what placement and care mean to him/her; however, for a child who lacks cognitive or verbal skills, drawing and play may provide relevant clues.

Relationship to and Meaning of Birth Family

Because a child in foster care and adoption always also belongs in part to the birth family, it is important to assess what the current relationship is between a child and the birth family and the significance that family has to the child. The meaning and importance of the birth family will depend on the age and developmental level of the child; the current membership, integrity, and level of functioning of the family; the circumstances and timing that led to the child's placement; the history of the child's experiences with the birth family; the child's understanding of care; and the goals of the placement.

Visits between a child in care and his/her birth parents are often sources of concern and tension. Although they provide an opportunity for a child to understand and resolve his/her foster care or adoptive status, such visits also provide opportunities for acting out feelings or for manipulation. To make visits a positive and valuable experience, the caseworker should attempt to ensure that all parties clearly understand the goals of care and the meaning of foster care or adoption.

If foster parents are viewed as a substitute extended family and the goal is the reunification of the birth family, most foster parents can comfortably support the birth parents' attempts to learn to become better parents. Foster parents do this by modeling positive parenting skills, encouraging the birth parents to perform parenting tasks when they visit (e.g., shopping with the child or helping with homework), and by teaching the birth parents parenting skills (such as grandparents might in a well-functioning extended family).

If foster parents are viewed as a substitute extended family and the goal is termination of the parental rights and adoption of the child, the role of the foster parents during visits depends on whether they intend to adopt the child. Most adopted special needs children are adopted by their foster parents. Often, the birth parents voluntarily release the child because they have come to know and trust the foster parents through visits, and the birth parents want the foster parents to adopt the child.

If some other family is to adopt the child, the foster parents can facilitate the adoption placement by using visits with the birth family to allow the birth parents and the child to come to terms with the fact that they will not be reunited. The foster parents' commitment to the adoption plan and the positive relationship they have established with the birth parents can serve as a bridge to the new family for the child. Such a process helps the child feel free to form new attachments without guilt and to adapt to the new situation.

One of the developmental tasks of an adopted child is to accept and resolve his/her dual heritage. The nature of the relationship between the adoptive family and the birth family can make a significant contribution to the success of the adoption. When the adoptive parents can figuratively accept the child's birth family into their home, much of the trauma of the adoption is alleviated, and a firmer basis for the child's identity is laid. Recently, there has been a trend toward a more literal acceptance of each other by the birth family and the adoptive family.

When there is an opportunity for some sort of relationship between the two families, the adoption is called an "open adoption." Because most older children enter adoption with a history of living with their birth families or with memories of the family, and because many of these children are in contact with the birth family when they are adopted, there is usually no choice about whether such adoptions will be open. Increasingly, however, infant adoptions are also becoming open. Birth and adoptive families may engage in a mutual selection process, may meet each other at the time of placement, and may agree to some contact following the placement. Although it is too early to assess the long-range effects of openness, such adoptions provide the adopted person with easier access to the birth family and a greater opportunity to get information and work out concerns about the reason for adoption. Open arrangements can be complicated and must be implemented very carefully, with all parties aware of the consequences.

Personal Style

Finally, it is important to assess the personal lifestyle of an older child in order to understand that child's needs and how best to ensure that placement in a substitute family will be successful. Lifestyle includes all of the idiosyncratic variables that make children so different from each other. Lifestyle is not necessarily related to a child's developmental level, his/her experiences with placement or loss, or to any of the other factors already listed. Often, the unique characteristics of a child cannot be measured objectively. It may be some unusual trait or characteristic, or it may just be the way that a child approaches life or the responses he/she engenders in others. For instance, some children have such infectious smiles that whenever they smile they alter their surroundings. Further, some children possess some inner determination that enables them to achieve far beyond their apparent capacity.

Although they are difficult to catalog or analyze, lifestyle behaviors are extremely important. Lifestyles frequently determine the compatibility of strangers. Relationships work best when people cherish each other's unique qualities and approach to life.

Making Use of the Assessment

Assessment is an ongoing process that can serve at least four purposes in helping abused and neglected children in family foster care or adoption. These purposes are as follows:

- to determine the capacity of a potential foster or adoptive family to meet the needs of a child who has been abused or neglected,
- to determine the specific strengths and weaknesses of a potential foster or adoptive family in order to make the most optimal match for a child with particular needs,
- to organize information about a particular child's needs so that the family can make an informed choice about whether it is willing to attempt to parent that child, and
- to anticipate the network of treatment and support services that should be utilized to make a placement helpful to a particular child and rewarding to the substitute care provider(s).

PROVIDING A SAFE ENVIRONMENT

The first and most essential task for the foster or adoptive parent is to provide a safe environment for the child to whom they are offering care. The next task is to help the child accept that the environment is, indeed, safe. For a child coming into care as a newborn, this security is provided through the consistent meeting of the infant's early developmental needs. The child may have been exposed to an unsafe prenatal environment. Furthermore, most children coming into care who are not infants have been exposed to an unsafe environment. Subsequently, the placement itself exposes these children to fear and uncertainty.

One aspect of security is the sense of commitment by the caretakers. This is an area in which many older children know their parents have faltered. Most of these children may already have experienced several other substitute homes. How can a child feel secure if he/she does not know how long it will be before he/she has to move again?

By definition, foster care is time-limited. Anxiety about what comes next is inherent, and all therapeutic interventions need to take this factor into account. Foster parents need to be careful not to deny the issue or the anxiety by reassuring the child that he/she is welcome to stay as part of the foster family. This gives the child a message with a double meaning, which can only confuse the child and make him/her feel less secure.

The sense of security will develop directly from the honesty of the caretakers and the willingness of those caretakers to help the child face, not deny, his/her anxiety.

Assessing a Substitute Environment

Child welfare professionals cannot guarantee that the environment into which a child has been placed is safe, but they can carefully evaluate families and use their knowledge and skills to try to assure that the child will be safe. Doing this poses something of a dilemma for those responsible for licensing, training, and monitoring substitute families. There are a large number of children waiting for adoptive families. Many of these children have been waiting a long time because meeting their special needs would prove too challenging for most conventional families. Generally, conventional families have little interest in parenting children not born to them, especially those children who most need permanent families. Furthermore, some of these families function well within the boundaries of their own experience, have led relatively problem-free lives, and have not had reason to develop the coping skills nor use the kind of resources that are necessary to parent special needs children. Adults who have had their fair share of problems are often the very persons who do not easily fit the model society has of the kind of parents who will provide a safe environment for a child.

Licensing requirements and agency guidelines for making assessments that provide security for children are not always congruent. Licensing tends to rule out categories of adults on the basis of statistical probability (e.g., persons convicted of certain felonies or indicted for abuse, etc.). Some agency guidelines try to accommodate the possibility that individuals grow and change, and that, in fact, some negative experiences may equip these adults to cope better with the difficulties that a child in substitute care may face. Careful assessment is necessary to determine how an individual has grown from past experiences.

There is always going to be some risk involved in placing a child in substitute care. Agencies that place special needs children try to keep arbitrary eligibility requirements to a minimum. These agencies use the orientation, assessment, and preparation process; caseworker assessment skills; and preplacement and inservice training to establish a cadre of homes that they feel are safe for a child. The agencies actively monitor the child's care and provide support services for the foster family.

Although there are no foolproof methods of predicting a family's response to a child or the child's safety in a home, there are predictive indicators. When foster parents have a child of their own, the child's general well-being suggests the quality of care the home provides. One of the criteria for successful substitute parents is their capacity to make and maintain a commitment to a child. During the assessment process, the child welfare caseworker needs to explore the nature of past commitments that the family has made and kept. A history of family stability in areas such as employment, housing, and social networks tends to predict stability in the future. Routine reference letters are of little value; however, personal contact with references, even by telephone, can give a picture of the family's personal history and characteristics. Of particular concern is the foster parents' extended family. Positive extended family relationships and activities suggest that a support system is already in place. Further, parents who show a sense of "connectedness" with their extended families transmit to the child the subtle, but very real message, of belonging. For a child in care, this sense of belonging is often one of the most significant ingredients lacking in the child's life experience.

Other issues that relate specifically to whether a child will be safe in his/her new family have been identified in the literature. For example, Bourguignon and Watson[29] suggest that there are eight "red flags" potential families present that signal possible danger. The red flags warn the caseworker to proceed with caution and investigate further. They are as follows:

- impulse control disorders;
- unresolved issues in personal history;

- history of a felony;
- extremely rigid moral or religious beliefs;
- significant problems in the rearing of other children;
- strong needs, and unrealistic expectations of the child or of themselves;
- history of mental illness or substance abuse; and
- marital difficulties.

Although no one red flag is in and of itself a reason not to proceed with placement of a child, any one *may* be, and the presence of two of more would certainly raise serious questions about the suitability of a placement plan.

A Good Placement Process

Caseworkers moving a child into care, or from one place to another, and the family that is receiving a new child into care need to work together to help the child feel safe in the new home. Agencies need to help the child understand that he/she lives in a world with many different parts, each of which is connected to the child's life. To ask a child to enter a new world, while completely closing a past one, is confusing—even devastating—and very rarely necessary. The agency must help the child form bridges between the present and the past.

Before the child visits a new home, it is helpful if the caseworker has assured an exchange of information between the child and the new family. This information may take the form of pictures, cards or letters; a videotape; telephone calls; or anything else that will help the placement seem less threatening. The first visit to the new home is critical, whether it occurs as a part of a preplacement process or occurs on the day the child moves in. Whenever possible, preplacement visits should be scheduled because they provide a chance for the child to get acquainted with his/her new surroundings and with the strangers who will soon be family. At the same time, these visits provide the child with a sense of security by returning to his/her current residence to sleep once more in familiar surroundings.

Moving into a new family is frightening. The child welfare caseworker and the family members must try to allay the child's fears. The greatest initial fear for a child coming into a new family is that all ties to the past will be severed permanently. The child may worry that the birth family will not know where he/she is, that he/she will never again see members of past foster families, or that the new family will not allow contact with old friends. Unfortunately, past placement practices all too often confirmed these worst fears. Now, however, sound practice works to reduce or eliminate those fears. The first thing a child should be shown in a new home is the bathroom; the second is the location of the telephone. The child should be encouraged to make calls to those persons who are significant to him/her. Any family rules about the use of the telephone should be stated clearly.

The first visit should focus on environment rather than relationships. Relationships may be one of the things the child finds most fearful, and there will be time in the future to develop relationships. Initially, a child can be helped to feel more secure by getting acclimated to his/her new surroundings. A tour of the living quarters ought to include opening every closet, a quick look under the beds, a tour of the attic, and a visit to the basement. Equally important, the new child should meet all of the people who live in the home.

After the tour, the child should be told the three or four most important family rules. Such "rule-sharing" reassures the child. There are rules here (not chaos), and the family will help the child understand what those

rules are. The few rules shared at that first visit should relate, if possible, to how the family ensures its members' own safety. Some examples are rules about leaving the house, respecting each other's privacy, and being in someone else's bedroom. The rules should be real, important, and simple.

COPING WITH REGRESSIVE BEHAVIOR

Professionals should assume that any child coming into foster care or adoption will manifest some reaction to the new home and that the most obvious sign will be some regression. The older the child and the more trauma that is associated with the placement, the greater the developmental regression. In addition, many of the children coming into care are already developmentally delayed. Therefore, many substitute parents are dealing with a child who may already manifest developmental delays and who is probably experiencing some developmental regression as a result of the placement.

It can be no surprise, then, that a child placed in foster or adoptive care is likely to exhibit immature behavior. One of the first things that substitute parents must learn is how to accept age-inappropriate behavior. They must learn how to respond to the child as he/she presents him/herself; yet, the substitute parents must provide the child with what he/she requires to begin to recover from any developmental delays. If a child is developmentally disabled or severely developmentally delayed, parents must also adjust their expectations to realistic levels.

The therapeutic process for helping a child with developmental problems begins with accepting the child in his/her current developmental stage. It also includes allowing or encouraging further regression to fill in earlier developmental gaps and then meeting the child's developmental needs in symbolic ways that do not inappropriately stimulate the child or encourage more infantile behavior.

There is a natural tendency for all of us to expect people to respond according to their chronological age or their physical size. "Act your age," is a common admonition that adults use with children. Telling a child that he/she is "too big" to be acting in a certain way is also common. Often, a child in foster or adoptive care does not behave in a way commensurate with the child's chronological age. This is usually difficult for the adults helping the child, whereas such behavior may actually be beneficial to the child. The child needs an environment in which he/she can regress, both to feel safe and cared for and to recapture some of the experiences the child may have missed earlier in life.

The first task of the substitute parent is to accept the behavior that the child presents. That does not mean to accept behavior that is harmful to the child or to others or that is otherwise violent or destructive. The substitute parent should keep in mind that the first need of a child is to feel safe. What is required is that substitute parents carefully and clearly establish the limits of acceptable behavior (as generous an interpretation as possible), while reassuring the child that any behavior that jeopardizes the security of the child or of others is not acceptable. Such behavior must be controlled by the parents until the child has the ability to control it. But even in controlling the child's behavior, the parents must accept it as part of the child. They must convey to the child that limiting the behavior is not denigrating the child. The limits are necessary for the child's or others' protection until such time when that the behavior is altered into a less dangerous form or is no longer necessary.

For example, a 6-year-old child who is angry with his foster mother may grab a butcher knife and threaten to stab her. The mother must disarm the child and protect herself and the child from serious harm. She must try to convey the message that such violent behavior is not acceptable yet recognize in her response the legitimacy of the child's anger and the need to express it. Necessary external control of a child's behavior should be followed as soon as possible by an opportunity for the child to act at a regressed age level in some way that is not harmful. This might be achieved by playing some game that is "younger than the child" or engaging in some childish activity that is developmentally related to the age at which the child was acting.

When a 12-year-old expresses rage through behavior that is appropriate for a 3-year-old, the child should not be encouraged to express rage in some other way. Rather, it is important that the adult try to meet the child's needs at the 3-year-old level of development. The focus should be on the child's developmental age, not on the child's rage. If the behavior would be "normal" for a 3-year-old, what are the developmental needs of a 3-year-old? Can they be met symbolically? Temporary regression is often necessary before the child can move on to more age-appropriate behavior.

HELPING CHILDREN WITH FEELINGS OF LOSS

Because the most important concern of a child in care is loss, this topic has occupied a significant amount of attention from therapists and authors.[30] Numerous techniques that are easy to learn, but not always easy to implement, have been developed to help a child deal with loss.

Loss is a universal experience. As people mature, they learn ways of dealing with feelings about being temporarily separated from those who are important to them as well as feelings about permanently losing loved ones. Any loss is always painful because of its immediate impact and because it awakens feelings and memories of earlier losses.

Because loss is a universal experience, parents and therapists already have the tools to help a child with his/her losses. Those adults can draw from their own experiences to understand and empathize with the child. What is necessary is a framework within which to understand loss and practice therapeutic intervention.

When a person suffers a loss, he/she grieves. The feelings of grief are strong, painful, and difficult to sort out. Although they never come one at a time or in perfect order, there are several stages common to the grieving process; these stages are identified by the feeling that is strongest at that time. Several theoretical models for examining the grieving process have been constructed. The model presented in this manual identifies the following five stages:

- **Denial**. At first, the individual doesn't want to believe the loss. He/she cannot endure the pain. So he/she pretends it is not true, or that it does not really matter. Sometimes people use excessive activity to keep the pain away, or they may withdraw and sleep a lot.

- **Guilt**. This is the second step once a person breaks through the denial. Surely, there was something the person did that caused the loss or something that he/she could have done to prevent it. The person thinks of all the unfulfilled plans and the promises that cannot be fulfilled. A child always feels responsible for a loss that he/she experiences, and for children older than age 4 or 5, guilt is usually a part of the grieving process.

- **Anger**. This stage usually follows guilt. The person questions why the loss occurred, feels it is not fair, and seeks some other person to hold accountable for the pain. Sometimes the fear that one's anger will hurt someone causes a person to block its expression and turn it inward, resulting in depression. Most children are usually quite open with their anger when they have permission to "own" this feeling.

- **Sadness.** This is the fourth stage of the grieving process. The denial, guilt, and the anger are all ways that people use to keep from feeling the sad impact of a loss. When an individual realizes that the loss has, indeed, occurred and that the impact of the loss cannot be undone by guilt or anger, there is an intense awareness of how much the lost person(s) will be missed, particularly during moments that had been shared and treasured (mealtimes, bed time, holidays, etc.). This sadness is so overwhelming and the pain so acute that it cannot be endured for long. Each person allows it to

come and go by retreating to one of the earlier stages. The sadness returns again, and in time a person is able to move through to the final stage.

- **Acceptance**. This final stage is never fully realized. Acceptance of a significant loss is never *total* acceptance. With acceptance, a person is able to focus energy on other aspects of life. Acceptance, however, resembles denial, and a person starts through the process again or goes back to one of the earlier stages. Each time we work through the process it becomes a little easier, a little quicker. Any new loss, of course, generates a new round of feelings, and pushes people back towards denial.

The only way out of the pain of a loss is to experience the grieving process. It is almost impossible to get through the process alone. To help a child through this process, adults must first reach within themselves to find and touch their feelings about a loss they have experienced. Then, the adults can try to identify what they think the child may be feeling, giving permission for the child to have that feeling, whatever it is. After accepting and sharing the child's feeling, the adult can very gently try to encourage the child to move on to the next level in the grieving process. The child may move on, refuse to budge, or retreat to an earlier stage. Whatever the child does is all right. If the move is forward, the adult again accepts and shares the feeling. If there is no movement or the child retreats, that too is accepted. There will be other opportunities. If the adults acknowledge that it is acceptable behavior, a child will allow him/herself to grieve.

The problem is that no adult likes to see a child in pain. The adults tend to join the child at the denial stage, argue the child out of the guilt stage, or fight back at the child in the anger stage. Thus, the adults do not have to endure the child's pain. They tell the child "Don't worry about the past," "Everything will be all right now," "It wasn't your fault you were moved," or "Don't talk to us that way because we're not responsible for what happened to you in the past." Again, the technique for helping is easy to learn but less easy to implement. The adults must allow the child to feel pain, quietly accept the child's pain, and through this sharing and support, make it somewhat easier for the child.

HELPING CHILDREN WITH ISSUES OF IDENTITY

Foster and adoptive parents have an opportunity and a responsibility to help any child in their care with issues of identity. Foster and adoptive parents can do this by respecting the child as an individual and by clearly understanding their role in the child's life.

The definitions of foster care and adoption that have been presented in this manual stress that a child in care already has another family—either one to which he/she will return or one which becomes part of a new kinship network when the child is adopted. The family of origin is always a significant part of the child's identity, and the child has a right to as much information about that family as is known. The foster or adoptive parents must learn all they can and share this information with the child. Even unpleasant background information must be shared. It is part of the child's heritage and identity. Foster or adoptive parents should answer the child's questions about his/her family simply and directly. The substitute parents should then attempt to respond to the feelings that prompted the question or that may have been rekindled by the response. Although it may sometimes be permissible to delay sharing some information with a child because it seems too destructive at that time, it is never permissible or helpful to withhold background information or to lie to a child about his/her history.

In helping a foster or adopted child develop his/her identity, it is important for foster or adopted parents to understand that they cannot change the foundations that the child brings to placement. Rather, the substitute parents must take what the child already has and add to it. Thus, the foster or adoptive parents must encourage the child to bring into his/her new home as much of his/her former self as possible. It means that the foster or adopted parents must cherish what the child brings. This is not always easy. Sometimes what the child

brings is not "nice." The child should be allowed to bring his/her cardboard boxes or plastic garbage bags with his/her often meager belongings. Further, the child should be allowed to bring his/her dirty clothes, bad manners and disturbed behavior, pictures and memories, and his/her name. The child will discard the boxes and garbage bags when he/she is certain these belongings are no longer needed. There will be time enough to sort through, wash, and replace the clothes when the child feels more secure. The child's manners will improve, and his/her behavior will change.

The child's photographs and memories are intrinsically valuable. Photographs and snapshots should be placed in a Life Book, and that book should be looked at and discussed to let the child know that his/her past is accepted as a significant part of the child's identity and to provide opportunities for the child to sort out and share his/her previous experiences.

All children, except for newborns or those who have been abandoned, bring their names with them when they come into foster care or adoption. Foster and adoptive parents must always exercise extreme caution about suggesting or accepting name changes. A name (whether a family name, a given name, or a nickname) is a fundamental part of a child's identity. Sometimes, foster or adopted parents assume that encouraging or allowing the child to change his/her name will hasten the child's sense of belonging to the new family. Rather, this behavior may be interpreted by the child as a message that what he/she brings from the past is not acceptable.

For foster parents, a good rule of thumb is to ask the child what he/she was called in the previous home and what other names the child may have used. The foster parents should not offer the child a choice about the name to be used in their home until they have explored the meaning the name has to the child. The child may "choose" a name that has been assigned in a former home but that has negative implications to the child. The foster parent should note whether a child gives only his/her first name, both the first and last names, or just the last name.

In talking with a child about his/her first name, one of the goals is to discern what the birth parents named the child and what name the parents actually used when addressing the child. In some situations, a name is one of the few things that the birth parents were able to give their child. If the child gives a first name only, the foster parent can ask who actually named the child and whether the child is accustomed to being called by that name. If the name the child is accustomed to is the name that the birth parents used, the foster parents should use that name. If the child protests, the foster parents have an opportunity to discuss the child's feelings about the name and about his/her birth family. If the name is different, the foster parents can use this opportunity to discuss the child's birth family and the meaning of the name to the child.

When asked about what they were called previously, some children give both the first and last names, or just the last name. In such cases, initial attention should be directed to the last name. By focusing on the last name, foster parents can clarify their role and help the child establish his/her sense of identity. If the child gives the birth family name, the foster parents can reinforce membership in that family and the child's right to that name. If the child gives a last name other than the birth family's name, the foster parents can clarify what the real birth name is and explore why the child chooses to use another name.

Frequently, foster children use the last name of the foster family with whom they reside. Because children are usually registered in school under the name on their birth certificate, the use of the foster family name may complicate the child's situation at school. It is acceptable for the child to use the foster family name if the child understands that the use of that name is temporary and that it is used only as a convenience during the period of time when the child is residing with that family. Discussion around this issue provides an excellent opportunity for foster parents to help the child understand the meaning of the foster care placement.

For adoptive parents, changing names provides a similar opportunity to help the child understand what adoption actually means. Except for some newborns, children arrive in adoption with a name. As with foster children, that name should be respected and accepted; however, in adoption a change of name is a symbol of a change of status. Changing the last name is a part of the legal adoption procedure. Changing the first name is also symbolically important and should not be done casually. Adoptive parents face a dilemma with a child who has been given a name by his/her birth parents. If they change that name, the child may sense rejection of a part of him/herself that was given by the birth parents. If substitute parents do not change the name, the child may feel not fully claimed as their child.

One solution is to try to do both—change the child's name, but retain the old name as part of the new name. This approach is easily accomplished by giving the child a new first name and using the old first name as a middle name or by changing the original last name to a middle name. When an older child who has long used his/her first name is adopted, it may be preferable to keep the original first name and add a new middle name at the adoption to reflect the change of family status. Because there is no limit on the number of middle names, some families add several family names as middle names in order to reinforce the new family's claim to the child.

The focus on belongings, memories, and names is often difficult for foster parents and adoptive parents for three reasons:

- They want to feel that the child is in their care is "theirs."
- They want to protect the child from the pain of past experiences.
- They want to feel that no matter what the child may have endured, their home offers an opportunity for new experiences that should not be encumbered by the past.

A child's past is important, of course, and cannot be changed. Foster and adoptive parents must help the child in their care accept whatever past he/she has had and build a better future from those experiences.

At the center of one's identity is the sense of one's self-worth. When a child speaks negatively about him/herself (whether about his/her appearance, name, foster care or adoptive status, or anything else), the best initial response of parents is to remain silent. It is tempting to rush forward with reassurance, but a more effective first step is to allow the child to "own" his/her feelings by empathizing with the feelings rather than by attempting to dissuade the child from expressing those feelings. At some later time, parents can praise some particular aspect of the child that they value. Parents can wonder aloud about where a particularly appealing trait, characteristic, or behavior came from—suggesting, perhaps, that it came from the birth family or another family in which the child lived. They can also remark about how all of what has happened has helped the child be what he/she is.

Children play for many reasons—to express their fears and feelings, to help work through past traumas, and to explore ways to deal with developmental issues. "Dressing up" and playing adult roles are ways that children practice "growing up." Foster and adoptive parents should encourage fantasy play but discourage the child from choosing a particular adult role early in life.

Substitute parents should also discourage the child from viewing his/her foster or adoptive status as the distinguishing characteristic of his/her being and from forming his/her identity around that core. A foster or adoptive child is first and foremost a *child* with the same developmental needs as any child. However, the child's earlier experiences or foster or adoptive status complicates his/her life and may make meeting those needs more difficult. It should never, however, lead to defining him/her as a "foster child" or an "adoptive child" for the child's entire lifetime.

The best way that foster and adoptive parents can help the child in their care develop a healthy identity is by serving as good role models. Children often unconsciously copy the behavior of the adults with whom they live. They are also trying to learn how to become an adult by watching and making conscious choices. One 10-year-old boy, who had never known his father, was living in his fifth foster home. One day his foster father asked him if he wondered what he was going to be like when he grew up. The boy said, "No, I know what I'm going to be like. I'll just remember the different foster fathers I've had and put together the best things about each to make myself."

HELPING CHILDREN WHO HAVE BEEN SEXUALLY ABUSED

A secure, stable family in which sexual behavior is appropriate and sexual boundaries are clear is the best foundation for the treatment of child sexual abuse. For caseworkers and prospective substitute parents, specialized training in helping children who have been sexually abused, however, is essential. Currently, most preservice foster and adoptive training programs are now directing attention to this subject.

Training is important not only for the content and the skills that can be imparted, but because of the highly emotional nature of sexual abuse. The behavior of a sexually abused child affects foster and adoptive parents in at least four critical areas—the parent's own sexuality, the child's sexuality, the act of molestation, and the child's response to the molestation. Sound training aids foster and adoptive parents become more comfortable in discussing sexual abuse and accepting that part of a child's history. At the same time, training programs provide instruction in practical ways to deal with a child who has been sexually abused.

The following are some basic guidelines for substitute parents to keep in mind when they attempt to discuss the abuse with their child:

- Use a private setting.
- Use informal body posture and sit at a level to ensure eye contact with the child.
- Control your emotions.
- Use the child's vocabulary, especially sexual terms.
- Give the child permission to express his/her feelings.
- Reassure the child verbally.
- Give the child permission to talk openly about the experience.
- Universalize the experience.
- Ask specific questions in response to what the child tells.
- Believe the child.[31]

The nature, frequency, onset, perpetrator, and duration of the sexual abuse all make a difference in terms of the meaning of the experience to the child. To the extent that foster or adoptive parents know about these circumstances, they can enhance their therapeutic endeavors. Frequently, details are not completely known or acknowledged. Because sexual abuse of most children takes place within the family setting, placement in a new family provides a healing milieu. There are some general principles about what that milieu needs to be to help most sexually abused children:

- The family must offer a secure environment, and the safety of the child needs to be of obvious paramount concern to the parents.
- The structure and organization of the family must be apparent and frequently articulated, and family roles and rules must be clear.
- Generational boundaries must be clearly delineated, and parental roles, responsibilities, and behavior distinguished from that of the child.
- Communication among family members must be open.
- Punishment should be immediate, consistent, and of short duration, and threats and promises should be avoided.

Safety and the Sexually Abused Child

This manual has stressed the primary importance of providing a safe environment for children coming into care. This is especially important for a child who has been sexually abused because those adults who were responsible for protecting the child in the past have harmed him/her instead. The child must learn to understand that he/she is valued and that he/she can trust the adults in this new family to keep this a "safe home." This message should be emphasized verbally and behaviorally.

Family Structure and the Sexually Abused Child

A sexually abused child has usually lived either in a chaotic, dysfunctional family or in a family with unclear parental boundaries. The clearer and more reliable the structure in the new family, the greater the probability that the child will feel safe. Foster and adoptive parents should be able to explain clearly to the child the role each family member plays. They should reiterate this message any time the child seems confused or tries to blur the roles. It is likely that the rules that govern family behavior will also have to be repeated. A few, simple, and reasonable rules will make it easier for the child to adjust to the new family while developing a sense of safety.

In particular, generational boundaries must be clearly drawn. Nothing offers a sexually abused child more protection than the reassurance that there are parental, child, and family activities. Only the latter activities are meant to include all family members. Parents should not try to participate with the child in all of his/her daily activities, and the child should not be not allowed to participate with the adults in all of their activities.

Communication and the Sexually Abused Child

A child who has been sexually abused has usually experienced situations in which communication was limited and in which a premium was placed on secrecy. In cases of incest, the child victim has been told to keep the sexual activity secret within the family structure, and in chaotic families, the child has been told to keep family secrets from the outside world. The child has been taught that open communication is harmful. Indeed, for some sexually abused children, their disclosure has actually resulted in the loss of their families. These children must learn that open communication offers opportunities both to resolve problems and to examine the pain of past experiences.

Guilt and the Sexually Abused Child

There are two particularly sensitive areas in working with a sexually abused child in placement—one is the child's guilt, and the other involves the complications of helping the child resolve being separated from the

birth family. Guilt is a common response for victims of sexual abuse. They often feel that they share responsibility for the abuse and for what happens to the adult abuser. All too often, however, the response to a child who acknowledges this guilt is to simply reassure him/her that the adult perpetrator is responsible for the abuse. The intent is to cognitively and verbally explain the adult responsibility and thereby relieve the child of guilt. Unfortunately, such a response is seldom, if ever, very effective. Although the child is not legally or morally responsible for the abuse, he/she may *feel* responsible for what happened. Any reassurances to the contrary will not be heeded until the child's feelings of guilt have been accepted.

A paradox central to treatment is that individuals cannot become anything other than what they are until they can accept what they are. The task of therapeutic intervention is to allow people to accept themselves at their worst so they can initiate change. To offer verbal reassurances to a victim of sexual abuse that he/she is not responsible for what happened is to deny the pain that the victim feels because he/she views him/herself as responsible. Before reassurance will have any impact, the child victim must feel that the helping adult understands his/her feelings of responsibility and guilt. That does not mean that the adult agrees with the child's perception, only that the adult validates it as the victim's perception. When the victim relates that he/she feels "dirty" and responsible for what has happened, the helping adult can respond by saying, "What a terrible feeling that must be for you." Once the feeling has been validated (often, after considerable repetition), the adult can introduce the cognitive "truth" with a comment such as, "I know that must be a very uncomfortable feeling for you. But children are not responsible for the actions of the adults with whom they live. You were sexually abused by an adult (or with the permission of the adult who should have been protecting you) and that is not your fault.

Reconciling Sexual Abuse Victims with Their Families

Because most sexual abuse involves a family member as the perpetrator, or at least as the responsible adult who condones such abuse, the reconciliation of an abused child with the birth family can be extremely difficult. This resolution involves the feelings of both the adults and the child. Again, professionals must understand that the child who is placed in care always lives in at least two families and that it is necessary for the child to integrate these two families before he/she can develop a sense of completeness and have a feeling of peace with him/herself. Thus, the child must make some sort of reconciliation with the birth family despite the child's abusive experience. The reconciliation does not have to include face-to-face contact, although this is often the best way for the feelings generated by the abuse to be settled. The foster or adoptive parent of the sexually abused child walks a fine line between acknowledging the ambivalent or angry feelings that the child has toward the family abuser while not condemning that parent as a person. It is essential that foster and adoptive parents resolve their own feelings about the adults who have abused the child; it is often necessary for them to seek support in accomplishing this difficult task.

Special training concerning the issues involved in caring for a sexually abused child is essential for foster and adoptive parents. Such content is now a standard part of most foster parent training programs. In many communities, special programs directed by qualified trainers deal solely with the subject of sexual abuse. Increasingly, comprehensive training materials on sexual abuse have become readily available.[32]

HELPING DRUG-EXPOSED INFANTS

As in sexual abuse, infant drug exposure is a subject in which foster and adoptive parents require special training. The drug scene is growing and constantly changing, and little is currently known about the long-range impact on infants prenatally exposed to drugs. However, most social service professionals are aware of many of the immediate consequences of drug exposure, and they can help foster and adoptive parents learn to effectively care for drug-exposed babies. Agency staff should be aware of the following eight general rules for the caring for such infants:

- Caretakers need to view the infant as a child with medical problems, not as the medical problem itself. Essential medical procedures should never prevent the caretaker from providing the social stimulation and affection that all infants require.
- Whenever possible, caretakers should visit the hospital before the child's discharge and always obtain a written summary of the infant's diagnosis, the treatments provided, and the necessary followup care.
- Caretakers should follow exactly as directed any procedures regarding care and medications.
- Caretakers should take special precautions to prevent the already vulnerable infant from the risk of further compromised health from other infectious diseases as well take care to limit the spread of infectious diseases that the infant might have.
- Caretakers should learn to use and be comfortable with medical or rehabilitative equipment, such as monitors or aspirators, that could be required for the infant's care.
- Caretakers should be consistent and prompt in responding to symptoms and meeting the needs of a drug-exposed infant. Meeting the baby's needs will not make the child more demanding or "spoil" him/her, but it will help the infant begin to develop a sense of trust and instill a sense of structure in the infant's everyday routine. It may even save the child's life.
- Caretakers should seek and use respite care, especially when caring for a child whose care routinely interferes with the parents' sleep.
- Caretakers need to know whom to contact in event of an emergency.
- Caretakers will require readily available support services from the agency that originally placed the child.

Many drug-exposed infants will present special medical or developmental problems depending on the type of prenatal substance abuse. The rates of preterm deliveries (birth at less than 37 weeks' gestation) for substance-exposed infants are significantly higher than for the general population.[33] The care of some of these infants can be quite technically complex (e.g., a child with gastrointestinal problems that necessitate intravenous feedings), and specially trained foster or adoptive parents may be necessary.[34]

During the first 15 months of life, some drug-exposed infants may present feeding problems. Caretakers may find the following practices helpful:

- Swaddle and hold the baby during feeding; never prop the bottles.
- Use bottles for feeding liquids only; use spoons for solid foods.
- Burp the infant frequently if her/she spits up after feeding (some babies need to be burped after each ounce).
- Feed an irritable baby in a quiet place, away from other children and distractions, and avoid sudden movements.
- Allow more time for feeding an unusually sleepy baby and, to keep the baby awake, provide extra encouragement, such as massaging the infant's back or rubbing the soles of the baby's feet while talking softly.

- Offer a pacifier for babies who have an intense need to suck, even after their stomachs are full, to avoid overfeeding.[35]

For drug-exposed infants who are irritable or easily overstimulated, caretakers can also:

- Swaddle the baby, with the baby's hands exposed.
- Walk and hold the baby close to the body, using a front carrier (the combination of swaddling, body contact, and gentle motion helps many fussy babies fall asleep).
- Bathe the baby in warm water, followed by a gentle massage.
- Place the infant face down on the caregiver's abdomen and gently massage the infant's back.
- Offer a pacifier.
- Speak softly.
- Gently rock the baby in a wind-up cradle or swing, but be sure that the infant's head is well supported.
- Play soft music in a quiet room and avoid bright lights, jostling, or loud noises.[36]

In addition to preservice training and involvement with the professional team serving the child in their care, foster and adoptive parents of a drug-exposed child require additional agency support. Ongoing agency training designed especially for these parents is a good way to meet this need. This approach enables the parents to regularly learn new techniques and skills for helping the child and allows the parents to gain support from others who also care for children with special needs.

Finally, it is important that foster and adoptive parents understand that Sudden Infant Death Syndrome (SIDS) can occur among drug-exposed infants in spite of excellent care and appropriate monitoring. Recent studies show that the incidence of SIDS is greater when young infants are placed face down in their cribs.

HELPING OTHER MEDICALLY VULNERABLE CHILDREN

In addition to children who are exposed to drugs or alcohol before birth, there are other children who are medically vulnerable, chronically ill, or developmentally disabled. Some children are born with congenital anomalies, disabilities, or susceptibilities to chronic illness; infections transmitted prenatally; low birth weights (perhaps as a result of the mother's young age or the failure of the mother to obtain adequate prenatal care); or birth injuries. Other children may become disabled as a result of an illness or accident later in childhood.

Some children who are medically vulnerable, chronically ill, or developmentally disabled come into foster care or adoption in infancy because their birth parents voluntarily seek alternate care arrangements because they feel unable to parent their children. Other medically vulnerable older children are placed in care because the demands of their care cannot be met by their birth parents, some of whom may have abused or neglected these children.

A substitute care provider for a child who is disabled and who has also been abused or neglected faces the difficult challenge of meeting the child's basic needs, helping the child master tasks and feelings related to his/her disability, helping the child overcome the trauma of abuse or neglect, and meeting the issues of substitute care.

Helping Disabled Children in Foster Care and Adoption

Foster and adoptive parents are the best resource for most children who are medically vulnerable, chronically ill, or developmentally disabled and who cannot be reared by their birth families. In all but the most serious situations, meeting the child's special caretaking needs and managing his/her medical regimen can be handled in a home situation if the caretaker is trained and supported by the agency and if community resources are available on an outpatient basis. Success depends on committed and capable foster or adoptive parents and a range of ancillary services offered by qualified, trained providers who are part of a well-managed, comprehensive plan.

A child with disabilities who enters foster care or adoption after infancy usually has difficulty trusting his/her caretaker and developing a positive self-image. Many of these children have experienced placement in other homes, institutions, or hospitals. As a result of these earlier placements, the child's mastery of those developmental tasks that are possible within the limits of his/her disability have been delayed. For some children, the capacity to form trusting relationships has been severely damaged. Most perceive that their disability is the reason for their placement, and for many that may actually be a precipitating factor. Even more troubled is the child who knows that he/she has come into substitute care because he/she has been disabled due to an abusive act by his/her parents.

Foster and adoptive parents caring for a child with a disability must help him/her feel safe, well cared for, and valued. Many of these children entering care may require immediate medical attention. A thorough assessment of the child's physical condition is essential both for planning and for helping the new family understand and accept the child's unique needs and limits. Each disabling condition brings its own set of complications for the child and his/her caretaker(s). For example, a child with cerebral palsy or spina bifida usually requires assistance with routine daily tasks such as eating, toileting, or mobility, and should benefit from physical, occupational and speech therapy. In contrast, usually a child with Downs Syndrome can be trained to manage routine caretaking tasks quite well but will require frequent medical attention as a result of one or more congenital abnormalities.[37]

Whatever the nature of their particular condition, there are a number of concerns that are shared in common among children who are medically vulnerable, chronically ill, or developmentally disabled. Most of these children must learn to cope with pain and to deal with some degree of incapacitation. Many have experienced hospital environments that generally were not geared toward children, and they have likely been subjected to intrusive and often unpleasant medical procedures. Some of these children must deal the side effects of medication. All face the future with uncertainty related to the issues of independence, self-care, social acceptance, further impairment, and possible early death. They must develop a self-image that can withstand inner doubts and external pressures.[38]

A person's self-image begins to form in infancy. The first view of self a child has is the reflection of his/her image in the eyes of caretaking adults. A child begins to perceive him/herself as worthwhile in response to the respect, love, and value the caretaker offers. Although a child's self-image continues to be influenced by the perceptions of others, as the child matures, this image is based less on those external perceptions and more on his/her own sense of achievement and competence. A healthy self-image depends on one's ability to feel that he/she has the capacity to cope both with current life situations and future events—by relying on internal resources and by making use of external resources when needed.

Because a child who is medically vulnerable, chronically ill, or developmentally disabled soon learns to see that his/her body does not work as well as that of most other children, it is important that the adult caretaker reflects back to the child how much he/she is valued and loved. It is important, also, for the caretaker to teach the disabled child ways to manage his/her environment and feelings in order to help the child gain a growing sense of his/her own competence.

Perhaps the hardest part of being a caretaker for a child who is medically vulnerable, chronically ill, or developmentally disabled is finding the balance between helping the child accept his/her limitations yet achieving the maximum within the restrictions imposed by his/her disabling condition. The caretaker must support the development of self-worth and the child's capacity to act in his/her best interests, yet manage not to place so great an emphasis on achievement that the child feels his/her value is determined by the capacity to please the adult caretaker(s).

Substitute Care Providers for Disabled Children

Just as there are a number of issues that are common among the wide range of disabled children, there are issues and concerns that are common among those who provide services to medically vulnerable, chronically ill, or disabled children. Unless they have had prior experience caring for a child with a similar condition, most prospective parents experience the following:

- anxiety about their own competence;
- confusion and anxiety about the complexities of managing the care of the child and the amount of time this will take;
- insecurity about how the care of this child will affect the family routine and other family members;
- concern about assuming a financial and emotional burden that may stretch beyond the limit's of the family's resources;
- worry about the child's prognosis and the capacity to handle the situation should the problems become worse or should the child die;
- concern about preparing the child to be self-sufficient by adulthood, or how to arrange for care throughout adulthood; and
- worry about what would happen to the child in care should they die or themselves become incapacitated.

All of these concerns are valid and must be addressed in the recruitment, training, and ongoing support of foster and adoptive parents serving this group of children. The following four guiding principles may help agencies recruit and develop such parents and may help them succeed:

- There is a difference in viewing a child as a whole child who is disabled and in viewing him/her as a disabled child.
- A child with severe disabilities still has the capacity for growth.
- Although parental love cannot overcome a child's physiological weakness or abnormality, it can help that child achieve his/her potential and live a satisfying life.
- The success of caring for a child who is medically vulnerable, chronically ill, or developmentally disabled is related less to the child's special needs than to the family's flexibility and coping mechanisms.

ESTABLISHING SUPPORT FOR FOSTER PARENTS

There is a critical shortage of foster parents. The number of children requiring foster care is increasing while the number of foster parents is decreasing.[39] Most children are coming into care as a result of abuse and neglect or because they are medically fragile. These children do not move out of foster care quickly. It takes time to rehabilitate birth families or to free a child for adoption. By the time they are free for adoption, many children are too old or too problematic for many adoptive families to feel they can parent them successfully.

The earlier sections of this manual have suggested the dimensions of the task that foster parents face today. To meet the needs of a child in care, foster parents need a strong commitment, a great deal of support, and specialized training. As mentioned earlier, the pool of potential foster parents has diminished. Meanwhile, the demographic profile of the American family has changed. More women are working outside the home because they wish to pursue careers or because their families need the additional income.

Although agencies are attempting to recruit and develop new foster families, children sometimes remain in emergency shelters or in hospital wards because there are no foster homes available for them. In addition to increased recruitment efforts, attempts to solve the problem include:

- placing children with extended birth family members who are licensed as foster parents;
- professionalizing foster care so that it can compete in the market place; and
- using small congregate care facilities, sometimes as shelter care or planned interim care for infants.

However, these alternate care settings can sometimes result in reduced efforts directed toward finding permanent families for these children.

FOSTER HOME RETENTION

Agencies are also working hard to retrain and retain the foster parents they have as well as engaging new foster families. Efforts at retention have generally focused on funding, training, and team support. Although these factors are all important, retention efforts should be examined in a broader historical context as well as in response to contemporary issues.

For the past 50 years, foster parenting has been a volunteer service. People have become foster parents for various reasons, including the following:

- job satisfaction,
- commitment to a worthwhile goal,
- extra income,
- nonmonetary recognition,
- new opportunities for learning,

- social contact,
- personal satisfaction, and
- as an attempt to resolve personal problems.

These reasons are neither arranged hierarchically nor are they mutually exclusive.

Financial Reimbursement

Money is valued by most of our society, and it is time that agencies reevaluate the fiscal aspect of foster parenting. In principle, agencies generally reimburse foster parents only for the direct costs of caring for the child. A stipulated monthly amount is intended to cover most of the costs of the child's basic needs. Certain itemized expenses may also be reimbursable. Frequently, the rate of reimbursement fails to cover the foster parents' out-of-pocket expenses, so that being a foster parent usually involves considerable financial drain.

The fiscal situation has worsened over the past several years. The dwindling supply of foster homes has coincided with the increased demand for care for more difficult children. Agencies have felt pressed to pay more to get the care they need for these children, but the foster care reimbursement rates have not even increased with inflation. The solution for many agencies has been to establish new higher paid categories of specialized care.

Originally, the differences in payment between foster families depended only on the age of the child in care. Some agencies began to designate certain families as "specialized foster homes" with higher rates of payment for care. Agencies also established different categories of specialization with new rates of reimbursement for "special" specialized homes. The amounts began to vary widely, based mainly on the subjective assessment of the needs of a child, and frequently, on the availability of other options. To make the situation even more complex, some agencies set rates for relatives who provide foster care, which are different from what those relatives would receive for taking care of the same child under Aid for Families with Dependent Children (AFDC).

A few agencies have professionalized their foster care programs by reimbursing parents on a fee-for-service basis. Most agencies, however, are caught in a fiscal quagmire. There is little question that increased payments attract new foster families. But equally important is the need to establish a fair and rational system for the distribution of funds to foster parents.

Personal Satisfaction

Although most people work at a job to receive income with which to live, some people put as much or more effort into activities that are not essential for livelihood because of the satisfactions those activities provide. One of the most important factors is a sense of existential accomplishment. As is the case for most child welfare caseworkers, foster parents are idealistic and invest in this work because they realize that, in a very real way, their contribution to the child for whom they care will make a difference in that child's life and in the kind of world that child will eventually help shape. In this way, the foster parents give added meaning to their own lives.

Another personal satisfaction to which everyone responds is recognition. Not only are foster parents not paid for their work, they rarely get recognition within the larger community. For every newspaper article extolling the virtues of foster parents (usually around Mother's Day in the "women's" section of a newspaper), there is likely to be another story reporting on the abuse that a child received while in the foster care system (usually a news story on page one of the newspaper). Foster parents may be applauded for their good work when

a child in their care excels in school or stars on the football team, but they are more usually criticized for bringing a troublesome child into the neighborhood or costing the local taxpayers money for services for a child who is an "outsider." The only real praise and support they get is from other foster parents who understand and appreciate the job they are doing or from child welfare agencies.

Most agencies recognize foster families because they know that a good foster care program is the backbone of all child welfare programs. Agencies cannot offer services to help keep children anchored in their birth families unless they can provide the short-term care that some children need while their families are being stabilized for their return. Agencies need to be creative in finding more ways to provide recognition to foster families both within the agency structure and within the general community.

Recognition and increased job satisfaction come together when foster parents are given the opportunity to participate not only in the decision-making process for the child in their care, but also in the process that shapes the child welfare system. Increasingly, foster parents are participating on agency committees and community task forces. The contribution of foster parents can be invaluable and the reward to them well worth the effort expended.

Foster care also offers another way for people to have their unique needs met or to gain new perspectives on troublesome issues. Some people become and remain foster parents to satisfy some idiosyncratic whim or to resolve some personal problem. Foster care puts people into new family constellations. Foster care gives them a chance to have new emotional experiences, while offering an opportunity to work out family problems. Many foster parents consciously view foster care as a way to undo or redo some aspect of their own maturation experience. One of the best foster parents in one agency spent a lifetime devoted to providing excellent care for several children born to her and for a series of very difficult foster children, fully aware that she was out to prove her mother wrong for telling her she would never be a good mother. There is nothing wrong with foster parents working out their own issues and having their own needs met through providing foster care, as long as this works for the benefit of the child in their care.

TRAINING

Foster parent training is an essential component of a good foster parent program. Training enables an agency to provide better care for a child and it helps retain foster parents. A characteristic of the best foster parents is their strong drive to grow and change. Training satisfies their thirst for knowledge and increases their job satisfaction. It provides opportunities for the parents to learn new ways to meet the needs of the child in their care and to help those child move along to permanent homes.

Most States have mandated training for all licensed foster parents. Some States use training manuals, curricula, or programs developed, tested, and marketed by national resources or training centers. (See the Appendix, "Foster Parent Training Programs," for examples.) Although such programs are excellent and comprehensive, other agencies prefer to develop their own training programs. Staff and foster parents involved in generating their own curriculum frequently have a higher investment in the success of the training. The curriculum is also more likely to meet the needs of that particular agency. Sometimes, agencies contract with State foster parent organizations or community colleges to develop and provide the training.

Differing approaches to foster parent training grow out of differences in goals and focus. These differences influence the timing, content, and format of the training programs. Some agencies train foster and adoptive parents or caseworkers and foster parents together. Others train each group separately. Some agencies believe that without extensive advance training, foster parents are not equipped to take a child; others believe that until a child is in the home, training is an intellectual exercise with little lasting benefit. Some agencies develop the training content in response to changing populations in care; others use a core curriculum; and yet others use a combined approach.

Foster parent training should be provided throughout a continuum of agency involvement. Agencies make independent decisions about approaches in the various phases, but most break training down into two major categories—preservice training, which occurs before the placement of a foster child, and inservice training, which occurs periodically while the child is in placement.

Preservice Training

Agencies differ in the way they perceive and use preservice training. Some incorporate it into their assessment and preparation process for prospective foster families; others offer it to new families after they have been approved, but before they begin serving the child. Some agencies believe extensive training *before* the placement of a foster child reduces foster parent anxiety and helps them succeed. Other agencies feel that preplacement training should be minimal. They argue that the capacity of foster parents to learn at this point is blocked by their anxiety about whether or when they will get a child. Until the foster parents actually have a child in their care, specific training has limited impact. The following questions illustrate the debate. When should foster parents be trained to deal with a sexually abused child? With so many children in foster care acknowledging previous sexual abuse, should all foster parents be trained in handling a sexually abused child before any child is placed with them? Is such training a poor use of time because new foster parents may not be able to relate to the material in the absence of caring for a real child? The issue remains unresolved.

Learning more about foster parent applicants is one of the major advantages of preservice training. When the training involves a considerable amount of group interaction, members sometimes become aware of areas of individual concern before the trainers can address such issues. Often through subsequent discussions, applicants themselves realize that they are, or are not, suited for foster parenting.

The length of the training and the content of the curriculum vary according to the goals and format. Preservice training offered by agencies usually attempts to accomplish the following goals:

- To explain the legal and policy framework within which foster care is provided.
- To orient new foster parents to the goals of the agency's foster care program and permanency planning concepts and to describe the types of children the program serves.
- To provide concrete, procedural information to reduce foster parent's anxiety in critical areas (e.g., handling medical emergencies, parental visits, procedures for reimbursement of expenses, etc.).
- To begin to develop foster care team affective and cognitive alliances.
- To answer questions, address myths, and alter stereotypes about foster care.
- To provide basic child development knowledge and beginning skills in foster parenting.

Content directed toward the last goal, of course, is the most flexible. Courses offered outside a given agency tend to spend more time on these components. Agencies offering their own training usually view the preservice training as part of a continuum, with training in foster parent skills occurring later in the process.

Inservice Training

Most agencies offer inservice training for their foster parents. Some States have mandated a certain number of hours of training annually as a requirement for foster parent relicensing. There is no dearth of content. As permanency planning has become more clearly defined as the goal of foster care, and as the special needs of the child coming into care are more apparent, the scope of the curriculum for training has expanded. The specific demands of the Adoption Assistance and Child Welfare Act (P.L. 96-272) and increased reporting

and documenting requirements have also added training content. Frequently, all-day workshops, focused around a particular theme or problem area, such as discipline, meeting the needs of a medically fragile child, or foster parenting a sexually abused child are provided for foster parents.

As with preservice training, agencies use various approaches to provide inservice training. Some agencies offer it themselves; others join in cooperative efforts; and others rely on courses in foster care, parenting, and child development offered through community colleges or adult education programs.

Some agencies have worked out their own curricula for training foster parents; some have used curricula that have been developed for use by the State or that are marketed by national resource centers or training organizations; and others have combined the two. Most agencies use their own material for teaching basic foster parenting skills and developing their agency teams, but rely on published material for specific topic areas, such as working with sexually abused children.

Because there is so much essential material to be included in foster parent training and because the content is expanding daily, it is difficult for any training program to be inclusive. The task is to decide what content is most essential at any moment and to constantly revise the training in response to new information and the evolving needs of foster families. Agencies have found that training programs are more effective when foster parents have been involved in making the decisions that shape the content and format. Several content areas, however, are common to inservice training programs. These include the following:

- critical issues in foster care;
- the basic developmental needs of children;
- the special needs of foster children;
- families as systems;
- working with children and families of color;
- the impact of placement on children, their birth families, and their foster families;
- dealing with separation and loss;
- helping children with attachment;
- developing self-esteem in foster children;
- the impact of abuse and neglect on children;
- helping the sexually abused child;
- caring for the medically fragile child;
- helping the older child in foster care prepare for independent living;
- fostering the developmentally disabled child;
- fostering gay and lesbian youth;
- first aid and cardiopulmonary resuscitation;

- disciplining foster children;
- dealing with family crises;
- helping the foster child move on to another family;
- working on the team;
- knowing and using community resources; and
- advocating for foster children.

Agencies should always be mindful that training offers opportunities for providing foster parents with special recognition by awarding training certificates or diplomas and by providing chances for media coverage. Further, many agencies utilize foster parents as trainers, thus providing additional recognition and enriching the training program.

SOCIAL CONTACT AND SUPPORT

A positive foster family support system offers parents easy access to agency personnel and other foster parents. Agency contact should not occur only at the agency's convenience or at a point of acute crisis, but must reflect the agency's perception that foster parents are valued team members whose input is solicited and used not only around the child in their care, but around the operation of the agency's foster care program. The agency begins to generate this sense of support in its initial orientation, assessment, and preparation, and maintains it by regular contact once the family is caring for the child.

New foster parents, especially, need to know that they can get help in an emergency at any time of the day or night. This can be done in a number of ways. An agency can establish a "crisis hot line" that enables a foster family to reach staff when the foster parents need help. A less costly approach is to develop a "buddy" system that pairs every foster parent with another, usually a new foster parent with an experienced parent. In an emergency, or just if they wish to talk, either parent can call the other. If the call comes as a result of an emergency, it may be possible to handle the crisis on the basis of the combined experience of the two sets of parents.

The sense of support, then, comes from an environment that begins with the formal agency structure and the professional assistance that is available, includes formal and informal contact between agency staff and foster parents, and encourages interaction among foster parents. Formal and informal contact with other foster parents helps meet the social needs of many foster parents. There are very few people in this world who are truly fascinated by stories about one's child or grandchild. There are still fewer who want to hear about one's foster child. Other foster parents are the best audience because they really understand and are truly interested.

Sometimes, foster families become so comfortable with each other that they care for each other's child at points of crisis or for occasional weekend breaks. Homes may have to be licensed for this sort of informal respite care, and the agency (or court) must always be informed of the plan. Such casual respite may not meet the needs of all families, and agencies need to develop formal respite homes as another source of agency support.

FOSTER PARENT ASSOCIATIONS

Groups external to the agency, such as State foster parent associations, are still another source of support. These organizations allow foster parents learn what is going on with families who are working with other agencies, focus their attention on common issues, and develop advocacy power they can use to bring about change.

Recently, many foster parent associations have developed. In addition to the National Association of Foster Parents, State and local associations have been established. These associations serve many useful purposes, including mutual support, information sharing, training, and advocacy. Some State agencies, recognizing the value of these organizations, encourage and support the operation of foster parent associations in various ways, including providing office space and supplies. Foster parent associations are of great value to agencies in offering training, gathering information, enlisting political support, orienting communities, and assisting with policy development.

REVIEW AND MONITORING

Every child welfare agency should have quality assurance programs. In addition, the Adoption Assistance and Child Welfare Act of 1980 provides that States receiving Federal funds for foster care must have their foster care programs monitored. One aspect of the Act requires that service plans for children in foster care be monitored on a regular basis through a foster care review system. The purpose of this review is to determine whether planning for children is directed toward permanency.

Three types of review have emerged—the internal administrative review, the external community review, and a combination of the two. The administrative review is established by the public agency to whom the Federal funds have been appropriated for children in foster care. The review team is usually made up of professionals whose job it is to monitor the case plans of children for whom placement funds have been allocated.

The community review board is entirely separate from the public agency providing services. Lay persons from the community are appointed to serve on this panel. Board members are neither employed by the State agency nor are they usually involved in child welfare work on a professional basis.

Each system has its strengths and weaknesses. An administrative review board is more efficient, the reviewers are experts in the field, and recommendations can be expedited quickly. The biggest drawback of this approach is that the reviewers are employed by the agency whose cases are being reviewed. The community review board is free to be more critical of the agency involved, but the board members are less knowledgeable and may have been selected for reasons unrelated to their special competence in this area. Some jurisdictions have worked out a combination that they hope captures the best of each plan.

Whatever the format, the goal and process is the same. The cases of children who are in foster care are reviewed using case record material; discussion with the professional staff who have been involved in the planning; and interviews with the children, their birth families, and their foster families. Active involvement and participation of the children and their families in the review process is always to be encouraged. The intent is not to review the professional decisions that have been made, but rather to assure that for each child, careful attention was paid to the decision-making process, and that those decisions have attempted to provide stable caretaking and a sense of permanence.

Another protection for children in foster care has come about through the development of the court-appointed special advocate (CASA) program. CASA volunteers work within the court system on behalf of individual children. These volunteers are trained in the basic tenets of child welfare and the role of the court and the agencies involved. On a case-by-case basis, CASA workers attend court hearings of children in foster care. They are there to make certain that the child's rights are protected and that agencies follow up in accord with the court's findings and recommendations.

BLUEPRINT FOR FAMILY FOSTER CARE IN THE

In 1991, a National Commission on Family Foster Care, appointed by the Child Welfare League of America and the National Foster Parent Association, published a report entitled, *Blueprint for Fostering Infants, Children, and Youths in the 1990's*. The *Blueprint*, the result of more than a year of deliberations by the 49-member Commission, delineated a comprehensive plan to reform the family foster care system to make it stronger and more responsive to the current and future challenges.

The *Blueprint* details the failure of our present family foster care system and attributes that failure to the fact that the system is, "... built on century-old premises that are no longer valid: (1) that children needing care are primarily dependent and neglected and can be helped through love alone; (2) that there are sufficient numbers of families with wage-earning fathers and at-home mothers willing and able to donate their time and money to 'fix' these children by the age of 18; and (3) that caseworkers have the time and skill to supervise foster home placements."[40]

The *Blueprint* identifies and discusses 10 fundamental beliefs that collectively define family foster care:

- All children regardless of age, sex, ethnicity, physical and emotional health, intellectual ability, and/or handicapping condition, are entitled to a family intended to be permanent and, as needed, to assistance under the Federal foster care program regardless of their parents' income or financial status.
- The family must be the primary focus of efforts to protect children and youth and to promote their growth and development.
- Family foster care must fulfill five critical tasks:
  - protecting and nurturing infants, children, and youth;
  - ameliorating developmental delays and meeting social, emotional, and medical needs resulting from physical abuse, sexual abuse, neglect, maltreatment, and/or exposure to alcohol and other drugs or HIV infection;
  - enhancing positive self-esteem, family relationships, and cultural and ethnic identity;
  - developing and implementing a plan for permanence; and
  - educating and socializing children and youth toward successful transitions to young adult life, relationships, and responsibilities.
- Parents must have services and support to facilitate family reunification and to maintain safe, healthy relationships, or to make decisions about alternate living arrangements intended to be safe, nurturing, and permanent.
- Foster parents must have a clearly defined role with identifiable competencies and supports.

- Family foster care social workers must have a clearly defined role with identifiable competencies and supports.
- Family foster care must be an integral part of comprehensive, coordinated services and must provide a team approach in which the needs of children—within the context of their families—are paramount.
- Children and youth in family foster care, their parents, and child welfare agencies must have legal representation to ensure and expedite the development and implementation of case plans and family service agreements that respect the developmental needs of children. Court proceedings concerning children and youth in family foster care must be speedy, skillfully conducted, and meticulous.
- Accurate, complete, and relevant data about the children, youth, and families served must be collected, analyzed, and disseminated on Federal and State levels to help in the design and delivery of effective family foster care services.
- Effective and accountable family foster care services require effective and accountable leadership in city halls, governors' offices, national organizations, the judiciary, the Federal Government, Congress, and the White House.[41]

Based on these beliefs, the Commission defines family foster care as "... an essential child welfare service option for children and parents who must live apart while maintaining legal and, usually, affectional ties. When children and parents must be separated because of the tragedy of physical abuse, sexual abuse, neglect, maltreatment, or special circumstances, family foster care provides a planned, goal-directed service in which the care of children and youths takes place in the home of an agency-approved family. The value of family foster care is that it can respond to the unique, individual needs of infants, children, youths, and their families through the strengths of family living, and through family and community supports. The goal of family foster care is to provide opportunities for healing, growth, and development leading to healthier infants, children, youths, and families, with safe and nurturing relationships intended to be permanent."[42]

The *Blueprint* presents 79 recommendations listed under 3 broad categories:

- Foster Parent and Social Worker Responsibilities (as a team and as an individual),
- Child Welfare Agency Responsibilities, and
- Public Policies and Legislation.[43]

The thrust of these recommendations is toward system reform, and many of them are accompanied by suggested action steps. Although none of the recommendations is directed specifically towards meeting the needs of abused and neglected children in substitute care, reforming and strengthening the foster care system will of necessity improve life for these children. The report is available from the Child Welfare League of America and is recommended for anyone concerned about foster children.

ISSUES IN ADOPTION FOR THE 1990's

Although there is no report comparable to *A Blueprint for Fostering Infants, Children, and Youths in the 1990's* that identifies concerns and makes recommendations for reforming adoption, there has been no dearth of interest in the subject nor lack of discussion of the critical issues. Through the popular media, many people have become aware of some of these issues, such as the decrease in the availability of healthy white infants for adoption, the number of adult adopted persons searching for their birth parents, or the controversy surrounding transracial adoptions. The professional literature has also explored the future of adoption.

In 1992, Watson identified the following four broad challenges facing adoption in the immediate future:

- the increasing number of children coming into the foster care system and the complexity of both the circumstances that bring them into care and their needs;
- a three-way division in providing adoption services among the independent practitioners, the voluntarily supported nonprofit agencies, and the public agencies;
- the need to restructure adoption funding so that the primary criterion for adoptive parenthood for those seeking healthy white infants will no longer be their ability to locate and pay for their child;
- a technology that is making parenthood possible in a variety of new and complicated ways with little awareness of the potential impact on a child as the "product" of these efforts.[44]

Journals such as *The Future of Children* have devoted entire issues to the subject of adoption,[45] and have presented articles identifying and discussing the following critical areas:

- compiling accurate and complete information on adoption in the United States,
- reviewing and restructuring adoption law,
- the adoption of children with special needs,
- current status and future prospects of international adoption,
- the continuing controversy about transracial adoptions,
- open adoption and the reduction of adoption secrecy,
- agency versus independent adoptions,
- the long-term outcomes of adoption,
- the adoption of drug-exposed infants, and
- children in poverty.

Likewise, a special "Adoption" issue of *Child Welfare* [46] explored open adoption and transracial adoption as major unresolved issues and also included additional articles on the available adoption statistics by State and on the disclosure of medical and social history in adoption.

The articles mentioned above and in the cited literature provide a comprehensive overview of the problems in adoption and of some possible solutions. More significantly, this research highlights a new awareness of the complexities of adoption and thus helps assure that some of the romantic assumptions and simplistic procedures of the past can be put to rest.

CONCLUSION

The number of children coming into foster care because they have been neglected or abused is increasing. In spite of the community's best efforts to reunify the families from which these children come, some will never return to their birth families or grow up with their birth relatives. Child welfare agencies know that the foster and adoptive families are the best resources for meeting the current needs of most of these children and for helping health their earlier trauma. A major challenge facing agencies is to identify, develop, train, and support the foster and adoptive families needed for this group of children. The ability of these families to provide love and good nurture for the children in substitute care is essential. Good caretaking in and of itself, however, is not enough. In addition, the child welfare caseworker and the substitute parents must understand the impact of placement on these children, be sensitive to the abuse and neglect issues that brought these children into care, know what to do to meet the specific needs and behaviors of the child in care, know when and how to locate and utilize other community resources, and work together as a team.

Although they both serve children who have had to live outside the family into which they were born, adoption and foster care developed independently from quite different historical roots. Each had a different legal basis, different sources of funding, different functions, and different clientele. Agencies viewed these services as quite different, and those agencies that provided both usually established separate departments and procedures for each.

Adoption was the preferred service for the child who could not grow up in his/her birth family because its legal base offered the child a greater sense of permanence. Funds from adopting parents supported adoption agencies. Traditionally, the largest group of adoptive parents were white couples who were seeking children who most resembled the child the prospective parents could not produce because of infertility. Usually, minority, older, or special needs children did not physically resemble the prospective parents. Thus, adoption was not usually an option for these children.

To some extent, that is still true today. Two factors, however, have significantly altered modern adoption. First, the decline in the birth rate, the availability of legal abortion, and the social acceptability of single parenthood have all meant that fewer white infants are available for adoption. Some couples who initially sought a healthy, white baby are now considering other children in agency foster care who have been waiting for adoption. Some of these parents have weighed the risk of adopting a medically vulnerable from an accredited agency against the risk of engaging in an independent placement of a seemingly healthy newborn.

More important than the decline in the number of babies available for adoption has been the focus on permanence for foster children and the availability of Federal funds that have helped to defray expenses incurred in the adoption of special needs children. Thus, a new population of potential adoptive parents, many of whom were already foster parents, could now afford to adopt. At one time, agencies were reluctant to allow foster parents to adopt the children for whom they had been caring. These families are now the greatest single resource for the adoption of children with special needs.

Furthermore, the current emphasis on kinship care has further blurred distinction between foster care and adoption. When a child's needs are being met by relatives who have become part of the formal child welfare system, the questions of whether that child should be adopted by those relatives warrants close examination. Although such adoptions may seem to offer greater legal security, resistance to the idea within the

family structure and changes that adoption can make in the functioning of the extended family system need to weighed carefully.

As the population of children coming into care has changed, agencies and substitute parents have learned a great deal about adoption and foster care. They face many complicated issues in further conceptualizing and delivering service. Although there are unique problems to solve in both adoption and foster care services, it seems clear that continued attention to their common characteristics and efforts to integrate these services will better meet the needs of children.

APPENDIX
SPECIAL TRAINING PROGRAMS FOR FOSTER AND ADOPTIVE PARENTS

FOSTER PARENT TRAINING PROGRAMS

The following four national organizations provide comprehensive foster parent training programs.

- Child Welfare League of America
  440 First Street, NW
  Suite 310
  Washington, DC 20001
  (202) 638–2952

Offers a comprehensive 18-hour training curriculum entitled *The Ultimate Challenge: Foster Parenting in the 1990's*, by E. Pasztor, M.Polowy, and M. Leighton (1991).

- The Child Welfare Institute
  1365 Peachtree Street, NE
  Suite 700
  Atlanta, GA 30309
  (404) 876–1934

Developed and markets a group program for the selection and preparation of foster and adoptive parents, *Model Approach to Partnerships in Parenting*, by H. Craig-Oldsen (1990).

- Institute for the Study of Children and Families
  The National Foster Care Resource Center
  Eastern Michigan University
  Ypsilanti, MI 48197
  (313) 486–0372

Developed a series of textbooks (many with instructor manuals and parallel foster parent workbooks), covering some aspect of foster care. The series is called the *Foster Parent Education Series* (1977–1986). Additional training materials for foster parents and child placing agencies are also available.

- National Resource Center for Youth Services
  University of Oklahoma
  202 W. 8th Street
  Tulsa, OK 74119
  (918) 585–2986

Developed and markets the *Advanced Course for Residential Child Care Workers*, a training curriculum designed for child care workers, foster parents, and others who work in the field of substitute care (1986–updated versions).

ADOPTIVE PARENT TRAINING PROGRAMS

- National Resource Center for Special Needs Adoption
  16250 Northland Drive
  Suite 120
  Southfield, MI 48705
  (313) 443–7080
  (313) 443–7099 (fax)

- North American Council on Adoptable Children
  1821 University Avenue
  Suite N–498
  St. Paul, MN 55104
  (612) 644–3036

The North American Council on Adoptable Children (NACAC) is not a direct-service provider. It is a non-profit, broad-based coalition of volunteer adoptive parent support and citizen advocacy group. caring individuals, and agencies committed to meeting the needs of waiting children in the United States and Canada. Since 1972, NACAC has sponsored the adoption community's largest annual conference, uniting concerns and resources of over 1,000 experience adoptive parents, child welfare professionals, and advocates. Other training events and specific technical assistance are also sponsored periodically.

- The Child Welfare Institute
  1365 Peachtree Street, NE
  Suite 700
  Atlanta, GA 30309
  (404) 876–1934
  (see above under Foster Parent Training Programs)

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GLOSSARY OF TERMS

Adoption - meeting the developmental needs of a child by legally transferring ongoing parental responsibilities for that child from birth parents to adoptive parents, recognizing that a new kinship network is created by the process that forever links the two families together through the child who is shared by both.

Adoptive Parents - adults who legally become parents of a child who was not born to them.

Attachment - an emotional connection between people based on their significant meaning to and affection for each other.

Birth Families - families to which children are related as a result of being born into them.

Birth Parents - parents who conceive and give birth to a child, whatever their future relationship may be to that child.

Case Management - helping clients identify, access, and coordinate community services that match their needs.

Child Sexual Abuse - activity or interaction whereby the intent is to arouse and/or control a child sexually.

Extended Family - those who are "related" to members of a nuclear family, such as the grandparents or aunts and uncles of a child (see also Kinship Network).

Family Foster Care - a means of temporarily meeting the developmental needs of a child by providing him/her with substitute family care for a period of time when neither the child's birth parents nor biological extended family can meet the child's needs.

Family of Origin - a person's parents and siblings by birth.

Family Preservation Services - social services intended to keep families together when the children are at imminent risk of removal. Usually such services are crisis oriented, short term, and offered in the home on an on-call basis.

Family Reunification - reestablishing a birth family by returning children who have been in substitute care.

Family Sculpture - the end result of a nonverbal technique that encourages family members to arrange themselves in a way that reveals their perceptions and feelings toward each other.

Foster Care - taking care of children and meeting their developmental needs outside of their own families on a short-term basis and without legally transferring full parenting responsibilities.

Foster Parents - those who assume, usually for a limited period of time, the day-to-day care of a child not born to them and for whom they do not have full legal parental rights.

Incest - sexual involvement between immediate family members (or between a child and the paramour of the child's mother).

Kinship Care - a form of foster care in which members of a child's extended birth family formally become his/her foster parents (also called Relative Foster Care).

Kinship Network - the group of people one considers one's "relatives." Relatives are defined on the basis of blood ties, legal action, function, or mutual affection and agreement. The boundaries of such a network are flexibly determined by law, culture, and individual choice.

Life Book - a scrapbook for children in substitute care that includes pictures, letters, documents, or other memorabilia.

Medically Fragile Children - children born vulnerable as a result of genetic or congenital difficulties or poor prenatal care, or who develop illnesses that necessitate special medical observation or care to assure their continued well-being.

Network - a number of people or organizations that are interconnected because of a common history, affectional tie, or agenda.

Open Adoption - an adoption is which there is a planned opportunity for contact between the birth family and the adoptive family. The contact may range along a continuum from an exchange of written information at the time of placement to regular, ongoing face-to-face contact between the two families throughout the child's lifetime.

Permanency Planning - an attempt to provide stability for children coming into substitute care by anchoring them in a family that can provide continuity to their care.

Reciprocity - mutual give and take in a relationship that respects the importance of both parties in meeting the needs of the other.

Sexual Abuse (see Child Sexual Abuse).

Special Needs Children - those children, who because of genetic, prenatal, birth, or developmental difficulties; age; membership in a sibling group that must stay together; or other limiting circumstances, present an additional challenge to prospective substitute parents.

Substitute Care - a means of meeting a child's daily caretaking and developmental needs outside of his/her home.

Substitute Parents - adults who agree to provide substitute care for a child in their homes, either formally or informally and on a temporary or long-term basis.

System - a group of similar items, ideas, or people that are interrelated to form a new entity that is greater than the sum of the component parts and that acts according to a set of principles that maintain its function, boundaries, and integrity.

Systemic Family Sexual Abuse - child sexual abuse within a family that is usually initiated or encouraged by the parents and involves multiple abusers.

Team - two or more people who have identified a common goal and have agreed to work together to achieve that goal.

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OTHER RESOURCES

ACTION for Child Protection
4724 Park Road
Unit C
Charlotte, NC 28203
(704) 529-1080

American Professional Society on the Abuse of Children (APSAC)
University of Chicago
School of Social Service
Administration
969 East 60th Street
Chicago, IL 60637
(312) 702-9419

Association for Sexual Abuse Prevention (ASAP)
P.O. Box 421
Kalamazoo, MI 49005
(616) 349-9072
(216) 221-6818

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
University of Colorado Health Services Center
Department of Pediatrics
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

Child Welfare League of America (CWLA)
440 First Street, N.E.
Suite 310
Washington, DC 20001
(202) 638-2952

Childhelp USA
6463 Independence Avenue
Woodland Hills, CA 91367
(800)4-A-CHILD or
(800)422-4453

Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013
(703) 385-7565

Community Leadership to End Abuse of Children (CLEAC)
2211 Riverside Drive
Suite 14
Ottawa, Ontario, Canada
K1H 7X5
(613) 738-0200

Military Family Resource Center (MFRC)
Ballston Centre Tower Three
4015 Wilson Boulevard
Ninth Floor
Arlington, VA 22203
(703) 385-7567

National Adoption Center
1500 Walnut Street
7th Floor, Suite 701
Philadelphia, PA 19102
(215) 735–9988
Toll Free: 1–800–TO–ADOPT

National Adoption Information Clearinghouse
11426 Rockville Pike
Suite 410
Rockville, MD 20852
(301) 231–6512

National Center for the Prosecution of Child Abuse
1033 North Fairfax Street
Suite 200
Alexandria, VA 22314

National Foster Parent Association, Inc.
226 Kilts Drive
Houston, TX 77024
(713) 467–1850

National Center on Child Abuse and Neglect (NCCAN)
Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services
P.O. Box 1182
Washington, DC 20013
(703) 385-7565

National Child Abuse Coalition
733 15th Street, N.W.
Suite 938
Washington, DC 20005
(202) 347-3666

National Children's Advocacy Center
106 Lincoln Street
Huntsville, AL 35801
(205) 532-3460

National Committee for Prevention of Child Abuse and Family Violence
332 South Michigan Avenue
Suite 1600
Chicago, IL 60604
(312) 663-3520

National Council on Child Abuse and Family Violence
6033 West Century Boulevard
Suite 400
Los Angeles, CA 90045
(818) 505-3422
(800) 222-2000

National Resource Center on Child Abuse and Neglect
American Humane Association
63 Inverness Drive, East
Englewood, CO 80122
(800) 227-5242
(303) 695-0811